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. 5 of 6

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ALPHABETICAL INDEX TO PETITIONER'S APPENDIX

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

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CERTIFICATE OF SERVICE

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

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Northeastern Nevada Regional Hospital
Medical Staff Bylaws

Adopted by the Northeastern Nevada Regional Hospital's Medical Staff on February 2014

Approved by the Northeastern Nevada Regional Hospital's Governing Board on February 2014

Northeastern Nevada Regional Hospital
Medical Staff ByLaws

Table of Contents

Northeastern Nevada Regional Hospital
Medical Staff ByLaws

Northeastern Nevada Regional Hospital
Medical Staff ByLaws

Northeastern Nevada Regional Hospital
Medical Staff ByLaws

Northeastern Nevada Regional Hospital
Medical Staff Bylaws

PREAMBLE

These bylaws are adopted in order to provide for the organization of the Medical Staff of Northeastern Nevada Regional Hospital and to provide a framework for self-governance in order to permit the medical staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These bylaws provide the professional and legal structure for medical staff operations, organized medical staff relations with applicants to and members of the medical staff and compliance with Nevada Revised Statutes

DEFINITIONS

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1. **ADMINISTRATOR** means the person appointed by the governing body to serve in an administrative capacity. No person disapproved of by a quorum of the medical staff will be appointed by LifePoint Hospitals, Inc. and approved by the Governing Board as Administrator.

2. **ANCILLARY STAFF** means non-physicians employed by members of the Medical Staff. These individuals do not require licensure, however, they do require documentation of education, training and/or certification to support the privileges requested. Such persons shall work under the direct supervision of their physician employer. They may not act independently in any capacity. The supervising physician will accept all responsibility for the conduct of these persons. The physician employer must provide malpractice insurance coverage for ancillary staff in amounts as outlined in the Medical Staff Bylaws. Ancillary staff include, but are not limited to, physician employed nurses, scrub technicians, and Ancillary staff members shall be subject to the Medical Staff Bylaws but shall not be members of the Medical Staff.

3. **AUTHORIZED REPRESENTATIVE** or **HOSPITAL'S AUTHORIZED REPRESENTATIVE** means the individual designated by the hospital and approved by the medical executive committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws.

4. **GOVERNING BODY** means the governing body of the hospital.

5. **CHIEF OF STAFF** means the chief officer of the medical staff elected by members of the medical staff.

6. **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.

7. **DISRUPTIVE BEHAVIOR/CONDUCT:** As cited in NRS 633 – Engaging in sexual conduct with the surrogate or a patient, including, without limitation, a spouse, parent or

legal guardian, which exploits the relationship between the physician and the patient in a sexual manner. Disruptive behavior with physician, hospital personnel, patients, members of the families of patients or any other persons if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient. Engaging in conduct which violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain. Failing to offer appropriate procedures or studies, to protest inappropriate denials by organizations for managed care, to provide necessary services or to refer a patient to an inappropriate provider, when such a failure occurs with the intent of positively influencing the financial well-being of the practitioner or insurer. Engaging in conduct that brings the medical profession into disrepute, including without limitation, conduct which violates any provision of a national code of ethics which has been adopted by the Board by regulation.

8. **HOSPITAL** means PHC-Elko d/b/a Northeastern Nevada Regional Hospital.

9. **INVESTIGATION** means a process specifically initiated by the medical executive committee to determine the validity, if any, of a concern or complaint raised against a member of the medical staff, Allied Health Professional Staff or Specified Professional Personnel staff and does not include activity of the medical staff aid committee.

10. **MEDICAL EXECUTIVE COMMITTEE** means the executive committee of the medical staff which shall constitute the governing body of the medical staff as described in these bylaws.

11. **MEDICAL STAFF** or **STAFF** means those physicians, podiatrists, and dentists who have been granted recognition as members of the medical staff pursuant to the terms of these bylaws.

12. **MEDICAL STAFF YEAR** means the period from January 1 to December 31.

13. **MEMBER** means, unless otherwise expressly limited, any physician, podiatrist, or dentist as defined in Section 2.2-2(a) and (b) holding a current license to practice within the scope of that license who is a member of the medical staff.

14. **ALLIED HEALTH PROFESSIONALS** means practitioners of Psychology practicing independently within the limitations of their license. They are not members of the Medical Staff, but are subject to all Bylaws, Rules and Regulations and other regulations that affect the Medical Staff. The Committee Chairperson should appoint an Allied Health Professional as a voting member of the Committee to which they are assigned at the time of appointment to the Allied Health Professional Staff.

15. **SPECIFIED PROFESSIONAL PERSONNEL** means non-physicians employed by members of the Medical Staff, hospital or by contract services whose work requires them to

exercise independent judgment in the diagnosis and treatment of patents. Such persons shall work under the supervision of members of the Medical Staff. These include, but are not limited to, advanced nurse practitioners and physician assistants, CRNA's and LCSW's. The Committee Chairperson should appoint a Specified Professional Personnel member as a voting member of the Committee to which they are assigned at the time of appointment to the Specified Professional Personnel Staff.

16. **TELEMEDICINE** means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from Hospital.

ARTICLE I
NAME

The name of this organization is the Medical Staff of PHC-Elko d/b/a Northeastern Nevada Regional Hospital.

ARTICLE II
MEDICAL STAFF MEMBERSHIP

2.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the medical staff and/or clinical privileges shall be extended to, and may be maintained by only those professionally competent physicians and dentists who continuously meet the qualifications, standards and requirements set forth in these bylaws. Except as otherwise provided in the medical staff rules and regulations, a physician or dentist, including those in a medical-administrative positions by virtue of a contract with the hospital, shall admit or provide medical or health-related services to patients in the hospital only if the physician or dentist is a member of the medical staff or has been granted clinical privileges in accordance with the procedures set forth in these bylaws. Appointment to the medical staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

Only physicians, podiatrists or dentists who:

(a) Document their (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, and (4) good judgment so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

(b) Are determined to (1) adhere to the ethics of their respective professions, (2) be able to work cooperatively with others so as not to adversely affect patient care, (3) keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) be willing to participate in and properly discharge the responsibilities determined by the medical staff;

(c) Maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be determined by the governing body with recommendation from the medical executive committee.

(d) Shall be deemed to possess basic qualifications for membership in the medical staff, except for the honorary and retired staff categories in which case these criteria shall only apply as deemed individually applicable by the medical staff.

2.2-2 PARTICULAR QUALIFICATIONS

(a) Physicians. An applicant for physician membership in the medical staff, except for the honorary staff, must hold an MD or DO degree or their equivalent and a valid and unsuspended certificate to practice medicine issued by the Medical Board of Nevada or the Board of Osteopathic Examiners of the State of Nevada. For the purpose of this section, "or their equivalent" shall mean any degree (i.e., foreign) recognized by the licensing boards in the State of Nevada to practice medicine.

(b) Limited License Practitioners.

(1) Dentists. An applicant for dental membership in the medical staff, except for the honorary staff, must hold a DDS or equivalent degree and a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of Nevada.

(2) Podiatrists. An applicant for podiatry membership on the medical staff except for honorary staff must hold a DPM degree and a valid, unrestricted and unsuspended license from the Nevada State Board of Podiatry.

2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the medical staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any

professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital.

2.4 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, sexual orientation, or physical or mental impairment that does not pose a threat to the quality of patient care.

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Responsibilities of each member of the medical staff include:

(a) Providing patients with the quality of care meeting the professional standards of the medical staff of this hospital;

(b) Abiding by the medical staff bylaws, rules and regulations and lawful standards, policies and rules of the hospital related to clinical practice and the medical staff.

(c) Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of medical staff membership, including committee assignments;

(d) Preparing and completing in a timely fashion medical records for all the patients to whom the member provides care in the hospital;

(e) Abiding by the lawful ethical principles of the Nevada State Medical Association or member's professional association;

(f) Working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care or disrupt hospital operations as defined;

(g) Abide by the ethical principles of physician's or dentist's profession and the hospital which include, but not by way of limitation, a pledge to:

(1) Refrain from fee splitting or other inducements relating to patient referral;

(2) Provide for continuous care of practitioner's hospitalized patients, without regard for the patient's age, sex, sexual orientation, religion, race, creed, color, ability to pay, or source of payment and disability;

(3) Seek consultation as required in the medical staff or department rules and regulations, or whenever warranted by the patient's condition or at patient's request;

(i) Participation in continuing education programs is documented as required for State Licensure. Each individual's participation in field-related continuing education and the findings of performance improvement activities is documented and considered in decisions about reappointment to the medical staff or renewal or revision of individual clinical privileges. Hospital-sponsored education activities will be offered.

(j) Active Medical Staff members will accept responsibility for emergency care and for support of the emergency rooms, including consultation and/or admission as may be necessary. Availability and assignment shall be in accordance with policies formulated by the departments, the medical executive committee and the governing body.

(k) Actively participate in and regularly cooperate with the medical staff in assisting the hospital to fulfill its obligations related to patient care, including but not limited to patient care audits, peer review, utilization review, quality evaluation and related monitoring activities required of the medical staff, and in discharging such other functions as may be required from time to time;

(l) Providing information to and/or testifying on behalf of the medical staff or an accused physician or dentist regarding any matter under an investigation pursuant to paragraph 6.1-3, and those which are the subject of a hearing pursuant to Article VII.

(m) Accept responsibility for participating in medical staff proctoring as an obligation of medical staff membership. Focused Professional Performance Evaluation availability and assignment shall be in accordance with regulations formulated by the departments and the medical executive committee;

(n) Cooperate with the medical staff in assisting the hospital in fulfilling its uncompensated or partially compensated patient care obligations; and

(o) Abide by all applicable laws and regulations of governmental agencies and comply with applicable standards of the joint commission on accreditation of health care organizations.

(p) Informing the appropriate authority (department head, medical executive committee or governing body) of previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration; voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital; and all final judgments or settlements involving the individual in a professional liability action.

(q) When admitting patients to inpatient services it is in accordance with state law and criteria for standards of medical care established by the medical staff contained in the medical staff bylaws and rules and regulations.

2.6 HARASSMENT PROHIBITED

Harassment by a medical staff member against any individual (e.g., against another medical staff member, house staff, hospital employee or patient) shall not be tolerated.

"Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

All allegations of sexual harassment shall be immediately investigated by the medical staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of medical staff privileges or membership, if warranted by the facts.

2.7 PERFORMANCE IMPROVEMENT ACTIVITIES

The medical staff will maintain a leadership role in the organization’s performance improvement activities. The performance improvement processes include, but are not limited to:

1) Medical assessment and treatment of patients;
2) Use of medications;

3) Use of blood and blood components;
4) Use of operative and other procedure(s);
5) Appropriateness of clinical practice patterns; and
6) Significant departures from established patterns of clinical practice.
7) Use of adverse privileging decisions for any practitioner privileged through the medical staff process;
8) Appropriateness of clinical practice patterns;
9) The use of developed criteria for autopsies;
10) Performance improvement mechanisms, measurement, or assessment includes the following: sentinel event data and patient safety data.

The medical staff will also participate in the measurement, assessment, and improvement of other patient care processes. These patient care processes include, but are not limited to, those related to:

1) Education of patients and families;
2) Coordination of care, treatment and services with other practitioners and hospital personnel, as relevant to the care of an individual patient; and
3) Accurate, timely and legible completion of patients' medical records.
4) Patient safety and satisfaction.
5) Findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner's competence.
6) Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.

2.8 HISTORY AND PHYSICALS

A medical history and physical examination must be completed and documented for each patient no more than thirty (30) days before or twenty-24 (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. An H&P is required prior to surgery and prior to procedures requiring anesthesia services, regardless of whether care is being provided on an inpatient or outpatient basis.

When the history and physical examination is conducted within thirty (30) days before admission or registration, an update must be completed and documented by a licensed practitioner who is credentialed and privileged by the hospital's medical staff to perform a history and physical examination. An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in Section 1861(r) of the Act) an oromaxillofacial surgeon, or other

qualified licensed individual in accordance with State law and hospital policy.

The update must accompany an examination for any changes in the patient's condition since the patient's history and physical examination was performed that might be significant for the planned course of treatment. If, upon examination, the licensed practitioner finds no change in the patient's condition since the history and physical examination was completed, he/she may indicate in the patient's medical record that the history and physical examination was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the history and physical examination was completed.

ARTICLE III
CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

The categories of the medical staff shall include the following: active, courtesy, consulting, provisional, honorary, retired, resident medical staff, temporary and administrative. At each time of reappointment, the member's staff category shall be determined.

3.2 ACTIVE STAFF

The active staff shall consist of those physicians and podiatrists, Dentists who regularly admit patients or otherwise actively participate in patient care within the hospital. The active staff shall meet the basic qualifications for staff membership according to Section 2.2. Their office shall be geographically located closely enough to the hospital to fulfill their obligations to the patients and the Medical Staff. Their primary residence or primary practice shall be within Elko County. Active staff will provide continuous care and coverage to their patients. They will participate in emergency room call as is appropriate to their specialty as per Section 2.5 (j) and without regard to a patient's ability to pay for care. These physicians will cooperate with administrative duties, attend meetings, have full voting privileges and may hold office. Active staff will have access to hospital facilities subject to any restrictions imposed by the Board due to contractual arrangements. They are eligible for due process according to Article VII.

3.2.1 SENIOR ACTIVE STAFF

The Senior Active Staff shall consist of those physicians, podiatrists, Dentists who have had privileges at least 15 years on the Northeastern Nevada Regional Hospital and/or Elko General Hospital Medical Staff and has achieved the age of 55. Those Medical Staff members would maintain the same rights and responsibilities as the Active members but would not be required to take Emergency Room unassigned call.

3.22 MEDICAL STAFF MEMBERS AGE 70

Medical Staff members, upon reaching age 70, without regard to number of years on the Medical Staff, will not be required to accept Emergency Room and unattended patient responsibilities

3.3 PROVISIONAL STAFF

The provisional staff shall consist of physicians, podiatrists and dentists who are active medical staff applicants and who are newly appointed to the medical staff, except for staff in training. The provisional staff shall be proctored in accordance with requirements established and outlined in Section 5.3. Provisional appointments are for not less than six (6) months and not longer than one (1) year, good cause extensions may be granted as approved by the MEC. The provisional staff is required to fulfill the requirements of their staff category according to their specialty, such physicians may not hold office and do not have voting privileges.

3.4 COURTESY STAFF

The courtesy staff shall consist of physicians, podiatrists, or dentists who occasionally admit and who are active members of the medical staff of another hospital accredited by the joint commission on accreditation of healthcare organizations. The courtesy staff must be sponsored by an active staff member who has committed to provide continuous care and treat complications as the need arises. These physicians must cooperate with administrative duties. They may attend staff meetings but may not vote.

Individuals whose primary residence is located within a 50 mile radius of the City of Elko, Nevada are not eligible for this category of staff membership.

Any Courtesy Staff member who has not had any activity at Northeastern Nevada Regional Hospital in the past two years will not be reappointed to the Medical Staff.

3.5 CONSULTING STAFF

The consulting staff shall consist of physicians, podiatrists or dentists who possess ability and knowledge so as to constitute an important adjunct in the care of difficult cases. Consulting staff may not admit patients but will provide consultation upon invitation of an active staff member. The active staff member will then provide continuing care as needed. The physician or dentist must cooperate with administrative duties. They may attend staff meetings but may not vote. Consulting staff members may not perform surgical procedures.

Any Consulting Staff member who has not had any activity at Northeastern Nevada Regional Hospital in the past two years will not be reappointed to the Medical Staff.

3.6 RESIDENT MEDICAL STAFF

3.6-1 QUALIFICATIONS

Resident medical staff membership shall be held by post-doctoral trainees (residents and fellows) in training programs of teaching institutions who are not eligible for another staff category and who are either licensed or registered with the appropriate State of Nevada licensing board. All resident medical staff members must obtain a license to practice medicine within the State of Nevada when eligible.

3.6-2 APPOINTMENT

3.6-2(a) Post-doctoral trainees who are enrolled in accredited residency training programs and who meet the above qualifications shall be appointed to the resident medical staff. Members of the resident medical staff are not eligible to hold office within the medical staff but may participate in other activities of the medical staff though membership on medical staff committees, with the right to vote within committees if specified at the time of appointment, and non-voting attendance at medical staff meetings.

3.6-2(b) All medical care provided by resident medical staff is under the supervision of members of the active, courtesy or consulting staff.

3.6-2(c) Appointment to the resident medical staff shall be for one year and may be renewed annually. Resident medical staff membership may not be considered as the observational period required to be completed by provisional staff. Resident medical staff membership terminates with termination from the training program.

3.7 HONORARY AND RETIRED STAFF

Honorary and retired staff members are not eligible to admit patients to the hospital, to exercise clinical privileges in the hospital, to vote, or hold office in this medical staff organization, but they may serve upon committees. They may attend staff and department meetings, including open committee meetings and educational programs.

(a) The Honorary Staff: The honorary staff shall consist of physicians and/or dentists, who do not actively practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital, and who continue to exemplify high standards of professional and ethical conduct.

(b) The Retired Staff: The retired staff shall consist of members who have retired from active practice and, at the time of their retirement, were members in good standing of the active medical staff for a period of at least three (3) continuous years, and who continue to adhere to appropriate professional and ethical standards.

3.8 ADMINISTRATIVE STAFF

Administrative staff category membership shall be held by any physician who is not otherwise eligible for another staff category and who is retained by the hospital or medical staff solely to perform ongoing medical administrative activities. These physicians and dentists must fulfill several qualifications as per Section 2.2-1 (a)(b)(d)

The administrative staff shall be entitled to attend meetings of the medical staff and various departments, including open committee meetings and educational programs, but shall have no right to vote at such meetings. Administrative staff members shall not be eligible to hold office in the medical staff organization, admit patients or exercise clinical privileges.

3.9 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these bylaws and by the medical staff rules and regulations.

3.10 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the medical staff, limited license members:

(a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the medical executive committee; and

(b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 5.4.

3.11 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the department chair, or pursuant to a request by a member, under Section 5.7, or upon direction of the governing body, as set forth in Section 6.1-7, the medical executive committee may recommend a change in the medical staff category of a member consistent with the requirements of the Bylaws.

3.12 TELEMEDICINE

3.12(a) Scope of Privileges

The medical staff shall make recommendations to the Governing Board regarding which clinical services are appropriately delivered through the medium of telemedicine, and the scope of such services. The Medical Executive Committee will review the services being provided via telemedicine on an annual basis.

3.12(b) Telemedicine Physicians

Any physician who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital through a telemedicine procedure (the "telemedicine physician"), must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Medical Staff Bylaws.

ARTICLE IV
APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, 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. Upon appointment, reappointment, or in the case of members of the honorary staff, by accepting an appointment to the medical staff, the medical staff bylaws, rules and regulations, and policies will be provided to each individual. By applying to the medical staff for appointment or reappointment (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these bylaws and agrees that throughout any period of membership that person will comply with the responsibilities of medical staff membership and with the bylaws and rules and regulations of the medical staff as they exist and as they may be modified from time to time. Appointment to the medical staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these bylaws.

4.1(a) The governing body has the authority, in accordance with State law, to appoint some types of non-physician practitioners, such as nurse practitioners, physician assistants, certified registered nurse anesthetists, and midwives to the medical staff.

4.2 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these bylaws, initial appointments to the medical staff shall be for a period of two (2) years. Reappointments shall be for a period of up to two (2) years.

4.3 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

4.3-1 APPLICATION FOR INITIAL APPOINTMENTS

Membership on the medical staff and/or clinical privileges shall be extended to, and maintained by only those professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these bylaws. A separate record is maintained for each individual requesting medical staff membership or clinical privileges.

(a) Pre-Application

(1) In order to apply for medical staff membership, the applicant must be able to document compliance with certain minimum objective criteria. This is done by completion of an application request form. The information that must be provided in completing this form includes: Nevada State license and (if applicable) current DEA registration; documentation of board certification, board admissibility, completion of an approved residency, or previous ten (10) years of practice; documentation of insurance coverage; documentation of where the applicant has practiced for the previous five (5) years; and confirmation of office/home locations.

(2) The information provided pursuant to Section 4.3-1(a) must demonstrate prima facie compliance with Section 2.2-1(a) of these bylaws.

(3) An applicant who is unable to satisfy Sections 4.3-1 (a) 1 and 2 above shall not be entitled to apply for medical staff membership. Moreover, such a practitioner shall not be entitled to the procedural rights set forth in these bylaws, but may submit comments and a request for reconsideration of the specific rule(s) which have adversely affected such practitioner. Processing of such comments and requests shall be in accordance with Article VII of these bylaws.

4.3-2 APPLICATION FORM

Membership on the medical staff and/or clinical privileges shall be extended to, and may be maintained by only those professionally competent physicians or dentists who continuously meet the qualifications, standards and requirements set forth in these bylaws.

(a) The application form shall be developed by the medical staff and shall be subject to approval by the medical executive committee and the governing body.

(b) Upon fulfillment of 4.3-1 the applicant shall be provided a complete application form for medical staff membership. The form shall be completed and returned to the chief of staff or designee. A completed application form is deemed to be a medical staff committee document; and it shall be afforded confidential treatment insofar as is allowed by law.

(c) When an applicant requests an application form, that person shall be given a copy of these bylaws, the medical staff rules and regulations, the hospital bylaws and summaries of other applicable policies related to clinical practice in the hospital, if any. The application shall include a statement of agreement to abide by medical staff bylaws, rules and regulations and such lawful and reasonable requirements imposed by the hospital.

(d) The form shall include peer references familiar with the applicant's professional competence and ethical character; It shall contain items concerning the following:
1. Medical/Clinical knowledge
2. Technical and clinical skills
3. Clinical judgment
4. Interpersonal skills
5. Professionalism
6. Communication skills

(e) The form shall include requests for membership categories, departments, and clinical privileges;

(f) The application shall also include statements regarding the applicant's involvement in any professional liability actions, pending challenges to licensure, any termination of medical staff membership or limitation, reduction, or loss of clinical privileges while under investigation or disciplinary action at another hospital or health facility, any information detailing government agency or third party payor investigation, proceeding,

or litigation challenging or sanctioning the physician's or dentist's patient admission, treatment, discharge, charging, collection, or utilization practices.

(g) The form shall include questions regarding physical and mental health status within any applicable limitations imposed by law;

(h) The form shall include questions regarding professional liability coverage, and

(I) The form shall include questions regarding criminal proceedings.

Each application for initial appointment to the medical staff, shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. An application fee will be charged. Fees are outlined in the Medical Staff Rules and Regulations.

4.3-3 EFFECT OF APPLICATION

By applying for or by accepting appointment or reappointment to the medical staff, the applicant:

(a) Signifies the applicant's willingness to appear for interviews in regard to the applicant's application for appointment;

(b) Authorizes medical staff and hospital representatives to consult with other hospitals, persons or entities who have been associated with him and/or who may have information bearing on the applicant's competence and qualifications;

(c) Consents to the inspection, by hospital representatives, of all records and documents including documentation regarding participation in continuing education programs, that may be material to an evaluation of the applicant's professional qualifications, conduct, and ability to carry out the clinical privileges that the practitioner requests, as well as, of the applicant's professional ethical qualifications for staff membership, regardless of who is in possession of these records;

(d) Consent to query the National Practitioner Data Bank;

(e) Releases from liability to the fullest extent of the law the medical staff and the hospital and its representatives for their acts performed in good faith in connection with evaluating the applicant;

(f) Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to hospital representatives concerning the applicant's ability, professional ethics, character, physical, mental and emotional stability and other qualifications for staff appointment and clinical privileges;

(g) Authorizes and consents to hospital representatives providing other hospitals, professional societies, licensing boards, and other organizations concerned with provider performance and the quality of patient care with relevant information the Hospital may have concerning him, and release the hospital and hospital representatives from liability for so doing;

(h) Consents to undergo and to release the results of a medical, psychiatric, or psychological examination by a practitioner acceptable to the medical executive committee, at the applicant's expense, (if deemed necessary) by the medical executive committee; and

(i) Signifies the practitioner's willingness to abide by all the conditions of membership, as stated on the application form, the reapplication form, and in these bylaws.

(j) Pledges to provide for continuous care for his or her patients.

For purposes of this Section, the term "hospital representative" includes the governing body, its individual trustees and committee members; the chief executive officer, medical staff specialist, all medical staff, departments, and officers and/or committee members having responsibility for collecting or evaluating the applicant's credentials; and any authorized representative of any of the foregoing.

4.3-4 PROCESSING THE APPLICATION

(a) Applicant's Burden: The applicant shall have the burden of producing adequate information for a proper evaluation of the applicant's experience, background, training, demonstrated ability, and, upon reasonable request of the medical executive committee or of the governing body, physical and mental health status (as evidenced by the results of a medical, psychiatric, or psychological examination conducted by a physician or dentist acceptable to the medical executive committee), and of resolving any doubts about these or any of the other qualifications specified in these bylaws.

(b) Verification of Information: The applicant shall fill out and deliver an application form to the chief of staff, or designee. The administrator shall be notified of the application. The application and all supporting materials then available shall be transmitted to the chair of each department in which the applicant seeks privileges and to the medical executive committee. The medical executive committee, and the administrator when requested to assist by the medical executive committee, shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. Verifications are obtained through primary sources when feasible. The hospital's authorized representative shall query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the medical executive committee for inclusion in the applicant's or member's credential file. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information. When collection and verification is accomplished, all such information shall be transmitted to the medical executive committee and the appropriate department(s).

(c) The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following:
1. A current picture hospital ID card
2. A valid picture ID issued by a state or federal agency (e.g. driver's license or passport).

4.3-5 DEPARTMENT ACTION

After receipt of the application, the chair of each department to which the application is submitted, shall review the application and supporting documentation, and may conduct a personal interview with the applicant at the chair's or committee's discretion. The chair or appropriate committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, and shall transmit to the medical executive committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The chair may also request that the medical executive committee defer action on the application.

4.3-6 MEDICAL EXECUTIVE COMMITTEE ACTION

The medical executive committee shall review the application, evaluate and verify the supporting documentation, the department chair's report and recommendations, and other relevant information. The medical executive committee may request additional information, return the matter to the department chair for further investigation, and/or elect to interview the applicant. The medical executive committee shall forward to the Chief of Staff, for prompt transmittal to the governing body a written report and recommendation as to medical staff appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also defer action on the application. The reasons for each recommendation shall be stated.

4.3-7 INCOMPLETE APPLICATION

If the medical executive committee is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise significantly incomplete, the medical executive committee may delay further processing of the application. If the processing of the application is delayed for more than thirty (30) days and if the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the affected physician or dentist shall be so informed. The applicant shall then be given the opportunity to withdraw his application, or to compel the continued processing of the application, but shall be informed that such an election shall not relieve him from the provisions of Section 4.3-4(a) of these bylaws. If the applicant does not respond within thirty (30) days, the physician or dentist shall be deemed to have voluntarily withdrawn the application. Such an applicant's application may thereafter be reconsidered within sixty (60) days only if all requested information is submitted, and all other information has been updated.

4.3-8 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Favorable Recommendation: When the recommendation of the medical executive committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the governing body.

(b) Adverse Recommendation: When a final recommendation of the medical executive committee is adverse to the applicant, the governing body and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to the procedural rights as provided in Article VII.

4.3-9 ACTION ON THE APPLICATION

Governing Body Action

(a) Upon Favorable Medical Executive Committee Recommendation: The governing body shall adopt, reject, or modify a favorable recommendation of the medical executive committee, or shall refer the recommendation back to the medical executive committee for further consideration, stating the reasons for the referral and setting a time limit within which the medical executive committee shall respond. If the governing body's action is adverse to the applicant, the chief executive officer shall promptly inform the applicant by special notice and the practitioner shall be entitled to the procedural rights as provided in Article VII.

1. The hospital must ensure that the practitioner and appropriate hospital patient care areas/departments are informed of the privileges granted by the governing body to the practitioner.

(b) Without Benefit of Medical Executive Recommendation: If the Governing Body does not receive a Medical Executive recommendation within the time period specified in Section 4.3-11(c), the Governing Body shall review the appropriateness of the delay. If the delay in time is ruled not justifiable by the Joint Committee, the Governing Body may take action. If such action is favorable, it shall become effective as the final decision of the Governing Body. If such action is adverse, the Chief Executive Officer shall promptly so inform the applicant by special notice, and the practitioner shall be entitled to the procedural rights as provided in Article VII.

(c) In the event the recommendation, or any significant part of it, of the medical executive committee is unfavorable to the applicant, the procedural rights set forth in Article VII shall apply.

(d) In the case of an adverse medical executive committee recommendation pursuant to Section 4.3-9(b) or an adverse governing body decision pursuant to Section 4.3-10(a) the governing body shall take final action in the matter only after the applicant has exhausted or has waived his procedural rights as provided in Article VII. Action thus taken shall be the conclusive decision of the governing body, or the governing body may defer final determination by referring the matter back to the medical executive committee for further reconsideration. Any such referral shall state the reasons therefore, shall set a reasonable time limit within which reply to the governing body shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receipt of such reply and of any new evidence in the matter, the governing body shall make a final decision either to appoint or reject the applicant. As used in this section, adverse actions are defined in Sections 6.1-4 and 7.2.

(e) The governing body shall give consideration to the actions and recommendations of the medical executive committee for making its recommendation and final decision, and in no event shall act in an arbitrary and capricious manner.

(f) The chief executive officer shall give notice of the governing body's final decision to the medical executive committee and (by special notice, if adverse) to the applicant. A decision and notice to appoint shall include: (I) the medical staff category to which the applicant is appointed; (ii) the department to which the physician or dentist is assigned; (iii) the clinical privileges the physician or dentist may exercise; and (iv) any special conditions attached to the appointment.

(g) Except as otherwise allowed by the medical executive committee or the governing body, an applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the medical staff for a period of two (2) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the medical staff or the governing body may require in demonstration that the basis for the earlier adverse action no longer exists.

(h) In the event the governing body should delegate some or all of its responsibilities described in this Article to one of its committees, the governing body shall, nonetheless, retain ultimate authority to accept, reject, modify or return for further action or hearing, the recommendations of its committee.

(i) Northeastern Nevada Regional Hospital has elected not to participate in an expedited credentialing / privileging process

4.3-10 TIMELY PROCESSING OF APPLICATIONS

Applications for staff appointments shall be considered in a timely manner by all persons and committees required by these bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following maximum time periods provide a guideline for routine processing of applications:

(a) Evaluation, review, and verification of application and all supporting documents by the medical staff office: no more than thirty (30) days from receipt of all necessary documentation;

(b) Review and recommendation by department: no more than thirty (30) days after receipt of all necessary documentation from the medical staff office;

(c) Review and recommendation by executive committee: no more than thirty (30) days after receipt of all necessary documentation from the department; and

(d) Final action: no more than ninety (90) days after receipt of all necessary documentation by the medical staff office or seven (7) days after conclusion of hearings.

(e) If the governing body does not receive a medical executive committee recommendation within the time period specified in Section 4.3-11, the governing body shall review the appropriateness of the delay. If the joint committee rules the delay in time not justifiable, the governing body may take action. If such action is favorable, it shall become effective as the final decision of the governing body. If such action is adverse, the chief executive officer shall promptly so inform the applicant by special notice and the physician or dentist shall be entitled to the procedural rights as provided in Article VII.

4.4 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

4.4-1 APPLICATION

(a) At least one hundred twenty (120) days prior to the expiration date of the current staff appointment (except for temporary appointments), a reapplication form developed by the medical executive committee shall be mailed or delivered to the member. If an application for reappointment is not received at least ninety (90) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. At least ninety (90) days prior to the expiration date, the medical staff member shall submit to the medical executive committee the completed application form for renewal of appointment to the staff for the coming term, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, criteria directly related to the quality of patient care, the matters set forth in Section 4.3-1, as well as other relevant matters. The applicant is also required to submit any reasonable evidence of current ability to perform privileges that may be requested. Upon receipt of the application, the information shall be processed as set forth in Section 4.3-4.

(b) Appraisal for reappointment to the medical staff or renewal or revision of clinical privileges is based on ongoing monitoring of information by the department head or executive committee concerning the individual's:

1. Medical/Clinical knowledge
2. Technical and clinical skills
3. Clinical judgment
4. Interpersonal skills
5. Professionalism
6. Communication skills

4.4-2 EFFECT OF APPLICATION

The effect of an application for reappointment or modification of staff status or privileges is the same as that set form in Section 4.3-3.

4.4-3 STANDARDS AND PROCEDURE FOR REVIEW

When a staff member submits an application for reappointment, or modification of staff status or clinical privileges the member shall be subject to an in-depth review generally following the procedures as set forth in Sections 4.3-4 through 4.3-11.

4.4-4 EXTENSION OF APPOINTMENT

If an application for reappointment has not been fully processed by the expiration date of the member's appointment, the staff member shall maintain membership status and clinical privileges until such time as the processing is completed unless the delay is due to the member's failure to timely complete and return the reappointment application form or provide other documentation or cooperation, in which case the appointment shall terminate. Any extension of an appointment pursuant to this Section does not create a vested right in the member for continued appointment through the entire next term but only until such time as processing of the application is concluded.

4.4-5 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure without good cause to timely file a completed application for reappointment shall result in the automatic expiration of the member's admitting privileges and expiration of their practice privileges and prerogatives at the end of the current staff

appointment, unless otherwise extended by the medical executive committee with the approval of the governing body. If the member fails to submit a completed application for reappointment within fifteen (15) days, past the date it was due, the member shall be deemed to have voluntarily resigned membership in the medical staff. A certified letter will be sent to the member for notification of the deemed resignation. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

4.5 LEAVE OF ABSENCE

4.5-1 LEAVE STATUS

At the discretion of the medical executive committee, a medical staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the medical executive committee stating the approximate period of leave desired, which may not exceed two years. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical staff.

4.5-2 TERMINATION OF LEAVE

At least 30 days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the medical executive committee. The staff members shall submit a summary of relevant activities during the leave, if the executive committee so requests. The medical executive committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and the procedures provided in Sections 4.1 through 4.5-5 shall be followed.

4.5-3 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for application for initial appointments.

4.5-4 MEDICAL LEAVE OF ABSENCE

The medical executive committee shall determine the circumstances under which a particular medical staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the medical executive committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a "medical leave" which is not granted for a medical disciplinary cause or reason.

4.5-5 MILITARY LEAVE OF ABSENCE

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the medical executive committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provision of Section 4.7-2 and 4.7-3, but may be granted subject to monitoring and/or Focused Professional Performance Evaluation as determined by the medical executive committee.

ARTICLE V
CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws or the medical staff rules and regulations, every practitioner or other professional providing direct clinical services at this hospital shall be entitled to exercise only those clinical privileges or services specifically granted to him, All individuals who are permitted by law and by the hospital to provide patient care services independently in the hospital have delineated clinical privileges, whether or not they are medical staff members.

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 REQUESTS

Each application for appointment and reappointment to the medical staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

5.2-2 BASIS FOR PRIVILEGES DETERMINATION

The delineation of an individual's clinical privileges includes the limitations, if any, on an individual's privileges to admit and treat patients or direct the course of treatment for the conditions for which the patients are admitted. Medical staff appointments or reappointments shall not confer any clinical privileges or rights to practice in the hospital. Each practitioner who is appointed to the medical staff of the hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, past performance, demonstrated competence and judgment, references and other relevant information. The applicant shall have the burden of establishing his/her qualifications for, and competence to exercise the clinical privileges he/she requests.

5.2-3 CONSULTATIONS

Consultations may be required at the discretion of the chief of staff. In addition, at the time of credentialing the department and/or medical executive committee will identify instances where consultation will be required as a matter of course.

5.2-4 REVIEW

A uniform level of quality of patient care shall be provided by all individuals with delineated clinical privileges.

5.3 FOCUSED PROFESSIONAL PERFORMANCE EVALUATION

5.3-1 GENERAL PROVISIONS

Except as otherwise determined by the medical executive committee, all initial applicants appointed to the medical staff, and all active staff members granted new clinical privileges shall be subject to a period of Focused Professional Performance Evaluation. Each appointee or recipient of new clinical privileges shall be assigned to a department by the medical executive committee. Performance of an appropriate number of cases as established by the department or the department designee and of the medical executive committee shall be observed by the chair of the department, or the chair's designee. The period of Focused Professional Performance Evaluation shall be at least six months but not more than one year to determine suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or the chair's designee. The member shall remain subject to such Focused Professional Performance Evaluation until the medical executive committee has been furnished with:

(a) A report signed by the chair of the department to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance. This report shall include a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department; and

(b) A report signed by the chair of the other department in which the appointee may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

5.3-2 FAILURE TO OBTAIN CERTIFICATION

(a) A provisional medical staff member who fails to complete the necessary number of proctored cases within the time frame established shall be deemed to have voluntarily resigned from the medical staff. Good cause extensions may be granted as approved by the MEC. Similarly, a medical staff member in any category who is subjected to Focused Professional Performance Evaluation as a result of seeking additional clinical privileges must complete the necessary number of proctored cases within the time frame established, or shall be deemed to have voluntarily relinquished the particular privileges subject to proctoring. There shall be no procedural rights associated with any such relinquishment. The member may reapply for membership or clinical privileges after six (6) months.

(b) A member who completes the necessary volume of proctored cases, but nonetheless fails to obtain the necessary certification of satisfactory completion of such cases may be terminated or privileges limited by the medical executive committee upon department recommendation (or in the case of applicants for additional privileges, such privileges may be terminated or limited by the medical executive committee upon department recommendation); however, the practitioner shall be afforded the procedural rights provided in Article VII.

5.3-3 MEDICAL STAFF ADVANCEMENT

The failure to obtain certification for any specific clinical privileges shall not, of itself, preclude advancement in medical staff category of any member. If such

advancement is granted absent such certification, continued proctorship on the uncertified procedure shall continue for the specified time period.

5.4 CONDITIONS FOR PRIVILEGES OF NON-PHYSICIAN PRACTITIONERS

5.4-1 ADMISSIONS

The management of each patient's care is the responsibility of a qualified licensed independent practitioner with appropriate clinical privileges. Other licensed independent practitioners who are permitted to provide patient care services independently may perform all or part of the medical history and physical examination, if granted such privileges and with direct supervision of a qualified member of the medical staff. The medical staff determines those non inpatient services, if any, for which a patient must have a medical history taken and appropriate physical examination performed by a qualified physician who has such privileges.

5.4-2 SURGERY

Surgical procedures performed by non-physician practitioners shall be under the overall supervision of the chair of the department of surgery or the chair's designee.

5.4-3 MEDICAL APPRAISAL

All patients admitted for care in the hospital by a non-physician practitioner shall receive the same basic medical appraisal as patients admitted to other services, and non-physician practitioners shall seek consultation with a physician member to determine the patient's medical status and need for medical evaluation whenever the patient's clinical status indicates the development of a new medical problem. Where a dispute exists regarding proposed treatment between a physician member and a non-physician practitioner based upon medical or surgical factors outside of the scope of licensure of the non-physician practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department.

5.4-4 – PSYCHIATRIC OR SUBSTANCE-ABUSE SERVICES

Until primary psychiatric or substance-abuse services are provided within this hospital, the written policies of the medical staff shall clearly define the care or appropriate referral of patients who are emotionally ill or who become emotionally ill while in the hospital.

5.5 TEMPORARY CLINICAL PRIVILEGES

5.5-1 CIRCUMSTANCES

Upon the written concurrence of the chief of the department where the privileges will be exercised and of the Chief of Staff, the Chief Executive Officer, or his designee may grant temporary privileges in the following circumstances:

(a) Pendency of Application: After receipt of an application for Staff appointment, including a request for specific temporary privileges, an appropriately licensed applicant may be granted temporary privileges for an initial period of 90 days, with subsequent renewals not to exceed 30 days. In exercising such privileges, the applicant shall act under the supervision of the chief of the department to which he is assigned and in accordance with the conditions specified in Section 5.5-3.

(b) Locum Tenens: A practitioner applying for temporary privileges in a locum tenens capacity shall follow the same procedure required for appointments and reappointments, as specified in Article IV. After receipt of an application for locum tenens appointment, including a request for specific temporary privileges, and completion of primary source verification, an appropriately licensed practitioner of documented competence who is serving as a locum tenens for a member of the Medical Staff may be granted temporary privileges not to exceed 120 days in a calendar year.

(c) Care of Specific Patients: Upon receipt of a written application for specific temporary privileges and written verification of satisfaction of the insurance requirements set forth in Section 2.2-1 (c), a practitioner who is not an applicant for membership may be granted temporary privileges for the care of one or more specific patients. Such privileges shall be restricted to the treatment of not more than four patients in any one-year by any practitioner. Practitioners requesting, with subsequent renewals not to excel permission to attend more than four patients in any one year shall be required to apply for Medical Staff membership before being granted the requested privileges.

5.5-2 APPLICATION AND REVIEW FOR LOCUM TENENS AND CLINICAL CARE OF SPECIFIC PATIENTS

(a) Upon receipt of a completed application and supporting documentation from a physician and dentist authorized to practice in Nevada, the governing body) may grant temporary privileges to a member who appears to have qualifications, ability and judgment, consistent with Section 2.2-1 and 2.2-2, but only after:

(1) The hospital's authorized representative has queried the National Practitioner Data Bank regarding the applicant for temporary privileges.

(2) The appropriate department chair has interviewed the applicant and has contacted at least one (1) person who:

(a) Has recently worked with the applicant;

(b) Has directly observed the applicant's professional performance over a reasonable time; and

(c) Provides reliable information regarding the applicant's current professional competence, ethical character, and ability to work well with others so as not to adversely affect patient care.

(3) The applicant's file, including the recommendation of the department chair, is forwarded to the medical executive committee.

(4) Reviewing the applicant's file and attached materials, the medical executive committee through the chief of staff or another designee recommends granting temporary privileges.

(5) In the event of a disagreement between the governing body and the medical executive committee regarding the granting of temporary clinical privileges, the matter shall be resolved as set forth in Section 4.3-10(d).

(b) If the applicant requests temporary privileges in more than one department, interviews shall be conducted and written concurrence shall first be obtained from the appropriate department chairs and forwarded to the medical executive committee.

5.5-3 GENERAL CONDITIONS FOR LOCUM TENENS AND CARE OF SPECIFIC PATIENTS

(a) If granted temporary privileges, the applicant shall act under the supervision of the department chair to which the applicant has been assigned, and shall ensure that the chair, or the chair's designee, is kept closely informed as to the applicant's activities within the hospital.

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the medical executive committee upon recommendation of the department or unless affirmatively renewed following the procedure as set forth in Section 5.5-2.

(c) Requirements for Focused Professional Performance Evaluation and monitoring, including but not limited to those in Section 5.3, shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges by the chief of staff after consultation with the departmental chair or the chair's designee.

(d) Temporary privileges may at any time be terminated by the chief of staff with the concurrence of the chair of the department or their designee, subject to prompt review by the medical executive committee. In such case, the appropriate department chair or, in the chair's absence, the chair of the medical executive committee shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of the replacement medical staff member.

(e) All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the medical staff.

5.6 EMERGENCY PRIVILEGES

In the case of an emergency, any member of the medical staff, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the medical staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the hospital.

5.6-1 DISASTER PRIVILEGES

The CEO, Chief of Staff, or his/her designee may grant disaster privileges when necessary to meet immediate patient needs after a Code Green (external disaster) or Code Yellow (internal disaster) has been activated. The CEO, Chief of Staff, or his/her designee is NOT required to grant disaster privileges to any individual and is expected to make such decisions on a case-by-case basis.

Those individuals granted disaster privileges will be assigned duties in accordance with the

hospital's Code Green (external disaster) of Code Yellow (internal disaster) plans, specifically E.D. physicians will triage patients and staff the Emergency Department, surgeons will report to the Surgery Department; family practice, internal medicine and pediatric physicians will report to the Med/Surg/Peds floor and obstetricians and assigned pediatricians will report to the Obstetrics Department. Each physician granted disaster privileges will be identified by a red temporary name badge that is signed by the COE, Chief of Staff or his/her designee. A list of practitioners granted disaster privileges will be kept at the Command Center and a copy provided to the Medical Staff Services Office once the situation is under control.

1. The CEO and or senior leadership in the absence of the CEO in collaboration with the Chief of Medical Staff or his/or her designee may assign disaster responsibilities.

2. Disaster privileges are only granted to volunteers when the Emergency Management Plan has been activated and the organization is unable to handle immediate patient needs.

3. The Medical Staff shall perform oversight of the professional performance of volunteer practitioners who receive disaster privileges through various mechanisms such as direct observation, mentoring or medical record review.

4. Volunteer practitioners will be provided a pictured identification badge provided by the Human Resource Department.

5. In order for volunteers to be considered eligible to act as licensed independent practitioners,
the hospital will obtain for each practitioner at a minimum a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
   a. A current picture hospital ID card the clearly identifies professional designation
   b. A current license to practice
   c. Primary source verification of license
   d. Identification including that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Core (MRC) or The Emergency System for Advance Registration of Volunteer Health Professionals Program (ESAR-VHP) or other recognized state or federal organization or groups.
   e. Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such as authority having been granted by a federal, state or municipal entity)
   f. Identification by a current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.

6. Primary source verification of licensure begins as soon as the immediate situation is under

control and is completed within 72 hours from the time the volunteer practitioner presents to the hospital.

7. In extraordinary circumstances when primary source verification cannot be completed within 72 hours there must be documentation of the following:
   a. why primary source verification could not be performed in the required time frame
   b. evidence of a demonstrated ability to continue to provide adequate care, treatment, and services
   c. an attempt to rectify the situation as soon as possible.

8. The hospital makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

5.7 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

The medical executive committee may recommend to the governing body a change in the clinical privileges or department assignment of a member. Such a recommendation may be pursuant to a recommendation of the department chair or to a request under Section 5.2-2. The medical executive committee may also recommend that granting of additional privileges to a current medical staff member be made subject to monitoring in accordance with procedures similar to those outlined in Section 5.2-2.

5.8 LAPSE OF APPLICATION

If a medical staff member requesting a modification of clinical privileges or department assignments fails to timely furnish the information necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article VII.

ARTICLE VI
CORRECTIVE ACTION

6.1 CORRECTIVE ACTION

6.1-1 CRITERIA FOR INITIATION

(a) Any person may provide information to the medical staff about the conduct, performance, or competence of its members. When reliable information

indicates a member may have exhibited acts, or conduct reasonably likely to be: (I) detrimental to patient safety or to the delivery of quality patient care within the hospital; (ii) unethical; (iii) contrary to the medical staff bylaws and rules or regulations; or (iv) below applicable professional standards, (v) disruptive of medical staff or hospital operation; (vi) an improper use of hospital resources, a request for an investigation may be initiated. Such a request may be initiated by the chief of staff, the medical executive committee, any department chairperson, the governing body or the chief executive officer.

(b) A recommendation for corrective action may also be initiated by any medical staff or department committee, with respect to activities, conduct, or performance within the scope of authority of that committee. Such recommendation shall be recorded in the minutes of that committee, and shall be reported to the chief of staff and the medical executive committee through the committee chairperson and/or the committee's minutes.

6.1-2 INITIATION

A request for an investigation must be in writing, submitted to the medical executive committee, and supported by reference to specific activities or conduct alleged. If the medical executive committee initiates the request, it shall make an appropriate recordation of the reasons.

6.1-3 INVESTIGATION

The investigation shall be conducted promptly by the appropriate department chief or an ad hoc committee, appointed by the chief of staff. Within thirty (30) days after completion of the investigation, a written report of the investigation shall be forwarded, together with any recommendations, to the chief of staff. If additional time is needed to complete the investigation, an interim report shall be forwarded, which should include a specific request for additional time to complete the investigation. Prior to completing its investigation, the practitioner against whom corrective action has been requested, shall have an opportunity to interview with the investigating committee. At such interview, the practitioner shall be informed of the specific nature of the investigation, and be invited to discuss, explain or refute the matters at issue. Such interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules set forth in Article VII shall apply.

6.1-4 MEDICAL EXECUTIVE COMMITTEE ACTION

Within thirty (30) days following the chief of staff's receipt of the investigative report, the medical executive committee shall consider the report, and, where appropriate shall take action, to include, without limitation:

(a) Rejecting the request for corrective action;

(b) Issuing a warning, or a letter of admonition or reprimand;

(c) Providing for proctors and ongoing review in accordance with Section 5.3;

(d) Recommending terms of probation or requirements of consultation;

(e) Recommending reduction, suspension or revocation of clinical privileges other than for temporary clinic privileges;

(f) Recommending reduction of medical staff category or limitation of any medical staff prerogatives directly related to patient care;

(g) Recommending suspension or revocation of medical staff membership. If suspension is recommended, the duration and terms of suspension, as well as the conditions precedent to reinstatement, shall be stated; or

(h) Taking other actions deemed appropriate under the circumstances.

Medical executive committee action period may be extended for up to thirty (30) days for demonstrated good cause.

6.1-5 SUBSEQUENT ACTION

If the medical executive committee's recommended action is as provided in Section 6.1-4 (a), (b) (c) or (h), such recommendation, together with all supporting documentation, shall be transmitted to the governing body. Thereafter, the procedure shall be as provided in Sections 4.3-9 and the following, as applicable:

(a) The medical executive committee's recommendation will be forwarded to the governing body; or

(b) Thereafter, the procedure shall be as provided in Section 4.3-10.

6.1-6 PROCEDURAL RIGHTS

Subject to the provisions of Section 6.2-3 (if applicable), any action by the medical executive committee pursuant to Section 6.1-4 (d), (e), (f) or (g), shall entitle the practitioner to the procedural rights as provided in Article VII.

6.1-7 INITIATION BY GOVERNING BODY

If the medical executive committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the governing body may direct the medical executive committee to initiate investigation or disciplinary action, but only after consultation with the medical executive committee. If the medical executive committee fails to take action in response to that governing body direction, the governing body may take corrective action, but this corrective action must comply with Articles VI and VII of these medical staff bylaws.

6.2 SUMMARY RESTRICTION OR SUSPENSION

6.2-1 CRITERIA FOR INITIATION

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person, the chief of staff, the medical executive committee, or the head of the department in which the member holds privileges may summarily restrict or suspend the medical staff membership or clinical privileges of such member. The governing body or chief executive officer may summarily suspend or restrict clinical privileges of a practitioner when no other person authorized by the medical staff is available, provided the governing body or chief executive officer has made reasonable attempts to contact the other person so authorized. Such a suspension is subject to ratification by the Medical Executive Committee. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible therefore shall promptly give written notice of the suspension to the practitioner, governing body, medical executive committee and chief executive officer. The summary restriction or suspension may be limited in duration in order to permit an investigation to be conducted. Unless otherwise indicated by the terms of the summary restriction or suspension, the practitioner's patients shall be promptly assigned to another practitioner by the department chief or by the chief of staff, considering, where feasible, the wishes of the patient in the choice of a substitute practitioner.

6.2-2 MEDICAL EXECUTIVE COMMITTEE ACTION

Within one week after such summary restriction or suspension has been imposed, a meeting of the medical executive committee (or a subcommittee appointed by the chief of staff) shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, according to such terms and conditions as the medical executive committee may impose, although in no event shall any meeting of the medical executive committee, with or without the member, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The medical executive committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two (2) working days of the meeting.

6.2-3 PROCEDURAL RIGHTS

Unless the medical executive committee recommends immediate termination of the suspension or restriction and cessation of all further corrective action (or suspension imposed by the governing body is terminated through lack of medical executive committee ratification within the time frame specified in Section 6.2-2), the practitioner shall be entitled to the procedural rights as provided in Article VII. The terms of the summary suspension or restriction as sustained or as modified by the medical executive committee shall remain in effect pending satisfaction of any conditions of reinstatement or a final decision by the governing body. There shall be no procedural rights associated with any suspension of seven (7) days or less that is rescinded or not ratified by the medical executive committee.

6.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be suspended or limited as described, and a hearing, if requested, shall be limited to the question of whether the grounds for automatic suspension as set forth below have occurred.

6.3-1 LICENSURE

(a) Revocation and Suspension: Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

(b) Restriction: Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the hospital which are within the scope of said limitation

or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

6.3-2 CONTROLLED SUBSTANCES

(a) If a current DEA is a requirement for hospital membership or the practice of specific privileges whenever a member's DEA certificate is revoked, limited, suspended, or expired, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(b) Probation: If a current DEA is a requirement for hospital membership or the practice of specific privileges, whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

6.3-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

Failure of a member without good cause to appear and satisfy the requirements of Section 11.6-3 may be basis for corrective action.

6.3-4 MEDICAL RECORDS

Members of the medical staff are required to complete medical records within such reasonable time as may be prescribed by the medical executive committee or otherwise provided by federal or state law. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the chief of staff, or the chief of staff's designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges" means on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within the hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the medical executive committee. Members whose privileges have been suspended for

delinquent records may admit patients in emergency situations. The suspension shall continue until lifted by the chief of staff or the chief of staff's designee.

6.3-5 LIABILITY INSURANCE

Automatic suspensions from medical staff membership shall be imposed for failure to maintain professional liability insurance in accordance with Section 2.2-1 (c). In addition, failure to maintain professional liability insurance for certain procedures shall result in automatic suspension of clinical privileges to perform those specific procedures. The suspension shall be effective until appropriate coverage is reinstated. In the event that the medical staff member is suspended for failure to obtain professional liability insurance within 15 days, the individual shall be deemed to have voluntarily resigned from the medical staff.

6.3-6 FAILURE TO COMPLY WITH GOVERNMENT AND OTHER THIRD PARTY PAYORS

The Medical Executive Committee shall be empowered to determine that certain specific rules and requirements of third party payors, government agencies, and professional review organizations are of a nature that compliance with such requirements by Medical Staff members and Allied Health Professionals or Specified Professional Personnel is essential to Hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. Upon general notice to the Medical Staff or special notice to the affected practitioner, a practitioner may be automatically suspended for failure to comply with such requirements. The suspension shall be effective until the practitioner complies with such requirements.

6.3-7 EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Section 6.3 through Section 6.3-7, the medical executive committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 7.3-1.

6.4 PRIVILEGES OF PHYSICIANS WHO ARE UNDER CONTRACT TO THE HOSPITAL

6.4-1 MEDICAL DISCIPLINARY RIGHTS

Any practitioner whose engagement by the hospital requires membership on the Medical Staff shall not have Medical Staff privileges terminated for any “medical

disciplinary" cause or reason without the same fair procedure provisions which are provided for other Medical Staff members pursuant to these Bylaws.

6.4-2 EFFECT OF CONTRACT

Privileges and medical staff membership of practitioners who are under contract to the hospital shall depend on the nature of the contract. If the contract is an exclusive contract, and the affected practitioner or practitioners are no longer members of the contracting group, those privileges covered by the exclusive contract as stated in the exclusive contract shall be automatically relinquished, subject to the provisions of Section 6.4-3. Those privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the due process fair hearing procedures of Article VII and VIII of these Bylaws upon termination of expiration of such practitioners contract or agreement with the hospital. If the contract is not an exclusive contract, such as a medical director's agreement or employment agreement, the practitioner's clinical privileges are not automatically altered or suspended upon termination or expiration of such contract or agreement with the hospital.

6.4-3 TERMINATION OF CONTRACT

Termination of contract practitioners as per their contract shall be the sole province of the administration; provided, however, that if the reason for a practitioner's contract termination or departure from the contracting group is based on a "medical disciplinary" cause or reason, the practitioner shall be entitled to the procedural rights specified in Article VII.

6.4-4 EFFECT OF SUSPENSION

If a contract practitioner is suspended from the Staff, the Hospital may terminate the practitioner's contract as provided by the contract.

ARTICLE VII
"FAIR HEARING PLAN"
(HEARING AND APPELLATE REVIEW)

7.1 GENERAL PROVISIONS

7.1-1 EXHAUSTION OF REMEDIES

If adverse action described in Section 7.2 is taken or recommended, the applicant or member must exhaust the remedies afforded by these bylaws before resorting to legal action.

7.1-2 APPLICATION OF ARTICLE

For purposes of this Article, the term "member" may include "applicant", as it may be applicable under the circumstances, unless otherwise stated.

7.1-3 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

7.1-4 FINAL ACTION

Recommended adverse actions described in 7.2 shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Governing Board.

7.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing:

(a) denial of medical staff membership;

(b) denial of requested advancement in staff membership status, or category;

(c) denial of medical staff reappointment;

(d) demotion to lower medical staff category or membership status;

(e) suspension of staff membership;

(f) revocation of medical staff membership;

(g) denial of requested clinical privileges;

(h) involuntary reduction of current clinical privileges;

(I) suspension of clinical privileges;

(j) termination of all clinical privileges;

(k) involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status and Section 5.3); or

(l) Any action reportable to the National Practitioner Data Bank.

7.3 REQUESTS FOR HEARING

7.3-1 NOTICE OF ACTION OR PROPOSED ACTION

A practitioner, against whom adverse action has been taken, shall promptly be given special notice of such action. Such notice shall:

(a) Contain a Notice of Charges consisting of a statement of the practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing;

(b) Advise the practitioner of the right to a hearing pursuant to the provision of Article VII and provide a summary of the rights granted in the hearing pursuant to these bylaws.

(c) State that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an appellate review on the matter;

(d) State that after receipt by the hospital of the practitioner's hearing request, the practitioner will be notified of the date, time and place of the hearing, and the grounds upon which the adverse action is based;

(e) List the witnesses expected to testify at the hearing to the extent known and request a list of the practitioner's witnesses; and

(f) Advise the practitioner that the action, if adopted, shall be reported to the Nevada State Board of Medical Examiners pursuant to Nevada Revised Statute. The notice will also state that the action, if adopted and required, will be reported to the National Practitioner Data Bank..

7.3-2 REQUEST FOR HEARING

The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the medical executive

committee with a copy to the governing body and chief executive officer. The physician will be advised in writing as to the time, place and date of the hearing, which will be no sooner than 30 days after the receipt of the request.

7.3-3 WAIVER BY FAILURE TO REQUEST HEARING

In the event the member or applicant does not request a hearing he shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.3-4 HEARING COMMITTEE

When a hearing is requested, the medical executive committee shall recommend a hearing committee to the governing body for appointment. The governing body shall be deemed to approve the selection unless it provides written notice to the medical executive committee stating the reasons for its objection within five (5) days. The hearing committee shall be composed of not less than three (3) members of the medical staff. The hearing committee shall gain no direct financial benefit from the outcome, and shall not have acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the hearing committee. In the event that it is not feasible to appoint a hearing committee from the active medical staff, the medical executive committee may appoint members from other staff categories or practitioners who are not members of the medical staff. Such appointment shall include designation of the chair. Membership on a hearing committee shall consist of, where feasible, an individual practicing the same specialty as the member.

(a) The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of hearing committee members and the hearing officer. Challenges to the impartiality of any hearing committee member or the hearing officer shall be ruled on by the hearing officer. The impartiality may only be challenged if the practitioner can prove actual bias or prejudice and must be done within 10 days of notice of the composition of the panel.

7.3-5 FAILURE TO APPEAR OR PROCEED

Failure without good cause of the member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

7.3-6 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of the time beyond the times permitted in these Bylaws may be permitted by the hearing officer on a showing of good cause, or upon agreement of the parties.

7.4 HEARING PROCEDURE

7.4-1 PREHEARING PROCEDURE

(a) Witness Lists: If known at the time of the Notice of Adverse Recommendation or Action (Section 7.3-1), the practitioner shall be given a list of witnesses (if any) who are expected to testify at the hearing. Within five (5) days of receipt of a request from the medical executive committee, the practitioner shall forward the list of anticipated witnesses. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least three (3) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

(b) Discovery Rights: (i) The practitioner shall have the right to inspect and copy, at the practitioner's expense, any documentary information relevant to the charges which the medical executive committee has in its possession or under its control, as soon as practicable after delivery of the practitioner's request for a hearing; (ii) the medical executive committee shall have the right to copy, at its expense, any documentary information relevant to the charges which the practitioner has in the practitioner's possession or control, as soon as practicable after receipt of the medical executive committee's request therefore; (iii) the failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for continuance; (iv) the right to copy by either party does not extend to confidential information referring to individually identifiable practitioners, other than the practitioner under review; nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information; and (v) the hearing officer shall rule on any contested requests for access to information sought that may be relevant to the charges. In making such rulings, the presiding officer may impose any safeguards the protection of the peer review process and justice requires. Moreover, in making such rulings and determining the relevancy of the requested information, the presiding officer shall, among other factors, consider the following:

(c) Pre hearing Motions: The parties shall be entitled to file preheating motions as deemed to give full effect to rights established by these bylaws, and to resolve such procedural matters as the hearing officer determines may properly be resolved outside the presence of the full hearing committee. Such motions shall be in writing and shall specifically state in the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have five (5) working days to submit a written response to the hearing officer, with a copy to the moving party. The hearing officer shall determine whether to allow oral argument on any such motions. The hearing officer's ruling shall be in writing and shall be provided to the parties promptly upon its rendering. All motions, responses, and rulings thereon shall be entered into the hearing record by the hearing officer.

7.4-2 REPRESENTATION

The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails, without good cause, to appear shall be deemed to have waived the rights to fair hearing. The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the medical staff in good standing or by a member of practitioner's local professional society. The medical executive committee or the governing body, depending on whose recommendation or action prompted the hearing, shall appoint an individual or individuals to represent it at the hearing, to present the facts in support of its adverse recommendation or action, and to examine witnesses.

(a) Attorneys for the Parties

The affected practitioner shall have the right, at the practitioner's expense, to attorney representation at the hearing. If the affected practitioner elects to have attorney representation, the medical executive committee may also have attorney representation. Conversely, if the practitioner elects not to be represented by an attorney in the hearing, then the medical executive committee shall not be represented by an attorney in the hearing. The affected practitioner shall state, in writing, the practitioner's intentions with respect to attorney representation at the time the practitioner files the request for a hearing. Notwithstanding the foregoing, and regardless of whether the practitioner elects to have attorney representation at the hearing, the parties shall have the right to utilize the assistance of legal counsel in connection with preparation for a hearing or an appellate review.

7.4-3 THE HEARING OFFICER

The medical executive committee shall recommend a hearing officer to the governing
body to preside at the hearing. The governing body shall be deemed to approve the selection unless it provides written notice to the medical executive committee stating the reasons for its objections within five (5) days. The hearing officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the hospital, the medical staff or the involved medical staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the hearing committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

7.4-4 RECORD OF THE HEARING

A reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer or practitioner. The cost of attendance of the reporter shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The hearing committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such an oath.

7.4-5 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member may be called by the medical executive committee and examined as if under cross-examination. Either party has a right to submit a written statement at the end of the hearing.

7.4-6 PROCEDURE AND EVIDENCE

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and representation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The hearing committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the hearing committee may request or permit both sides to file written arguments.

7.4-7 OFFICIAL NOTICE

In reaching a decision, the hearing committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Nevada. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party shall be given the opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority (the manner of such refutation to be determined by the hearing officer).

7.4-8 BURDEN OF PRODUCING EVIDENCE, BURDEN OF PROOF

(a) The body making the adverse action or recommendation shall have the initial obligation to present evidence in support of that action or recommendation.

(b) Thereafter, initial applicants (including staff members requesting new clinical privileges) shall bear the burden of persuading the hearing committee, by a preponderance of the evidence, of their qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for staff privileges or membership. Initial applicants shall not be permitted to introduce information not produced upon request of the peer review body during the application process, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for initial applicants, the medical executive committee shall bear the burden of persuading the hearing committee, by a preponderance of the evidence, that the action or recommendation is reasonable and warranted.

7.4-9 PRESENCE OF HEARING COMMITTEE MEMBERS AND VOTE

A majority of the hearing committee must be present throughout the hearing and deliberations. In unusual circumstances where a committee member must be absent from any part of the proceedings, that member practitioner shall not be permitted to participate in the deliberations or the decision unless and until he reads the entire transcript of the portion of the hearing from which he was absent. The final decision of the hearing committee must be sustained by a majority vote of the number of members appointed.

7.4-10 RECESSES AND ADJOURNMENT

The hearing committee may recess and reconvene the hearing, without additional notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing record shall be closed. The hearing committee shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of its deliberation, the hearing shall be declared finally adjourned.

7.4-11 HEARING COMMITTEE REPORT AND FURTHER ACTION

(a) Hearing Committee Report. Within thirty (30) days (five [5] working days if a summary suspension is involved) after final adjournment of the hearing, the hearing committee shall render its decision in writing. The decision shall include the hearing committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached.

(b) Report. The hearing committee report shall be sent to the parties to the hearing together with the notice of a right to appeal and a written explanation of the procedure for appealing the decision. The report will also be sent to the governing body.

7.5 APPEAL

7.5-1 TIME FOR APPEAL

Within ten (10) days after receipt of the decision of the hearing committee, either the member or the medical executive committee may request an appellate review. A written request for such review shall be delivered to the chief of staff, the administrator, and the other party in the hearing. If a request for appellate review is

not requested within such period, that action or recommendation shall be affirmed by the governing body as the final action if it is supported by substantial evidence following a fair procedure.

7.5-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for an appeal and a clear and concise statement of the facts in support of the appeal. An appeal shall be based upon one or more of the following grounds:

(a) The recommendation of the hearing committee is arbitrary, capricious or not supported by substantial evidence;

(b) The substantial failure of the hearing committee to follow the procedure outlined in the medical staff Bylaws; or

(c) The failure of the medical executive committee to report accurate information to the National Practitioner Data Bank.

7.5-3 TIME, PLACE AND NOTICE

If an appellate review is to be conducted, the appeal board shall, within fifteen (15) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than thirty (30) days, nor more than sixty (60) days from the date of such notice, provided however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) days from the date of the notice. The time for appellate review may be extended by the appeal board for good cause.

7.5-4 APPEAL BOARD

The governing body may sit as the appeal board, or it may appoint an appeal board, which shall be composed of not less than three (3) members of the governing body. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the
proceedings, but that attorney shall not be entitled to vote with respect to the appeal.

7.5-5 APPEAL PROCEDURE

The proceedings by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the hearing committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the hearing committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the hearing committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the governing body its written recommendations as to whether the governing body should affirm, modify, or reverse the hearing committee decision, or remand the matter to the hearing committee for further review and decision.

7.5-6 APPEAL BOARD REPORT AND FURTHER ACTION

(a) Appeal board report. Within 30 days (5 days if summary suspension is involved) after conclusion of the appellate review, the appeal board shall render its decision in writing. The decision shall include the appeal board's findings of fact and a conclusion articulating the connection between the hearing committee's decision, the evidence and the final decision of the appeal board.

(b) Report. The appeal board report shall be sent to the parties to the hearing, and the governing body.

7.5-7 RIGHT TO ONE HEARING

No member shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any matter, which shall have been the subject of adverse action or recommendation.

7.5-8 WAIVER

If, at any time after receipt of special notice of an adverse recommendation or action, a practitioner fails to make a required appearance or otherwise fails to proceed or to comply with this fair hearing plan, the practitioner shall be deemed to have consented to such adverse recommendation or action and to have voluntarily waived all rights to which the practitioner might otherwise have been entitled under the medical staff Bylaws or under this fair hearing plan.

7.5-9 CONFIDENTIALITY

(a) To maintain confidentiality, and to ensure the unbiased performance of peer review, disciplinary, and credentialing functions, medical staff members participating in any stages of the fair hearing process shall limit their discussion of the matters involved to the formal avenues provided in the medical staff Bylaws and this fair hearing plan.

(b) All proceedings conducted pursuant to this Article VII shall, unless otherwise ordered by the governing body pursuant to a request of the affected applicant or medical staff member, be held in private or executive session. An applicant or medical staff member whose medical staff privileges are the direct subject of the hearing may request a public hearing. Prior to exercising its discretion on any request for a public hearing, the governing body shall seek and consider the comments of the medical executive committee as to the implications and feasibility of conducting such a hearing in public.

7.5-10 RELEASE

By requesting a hearing or appellate review under this fair hearing plan, a practitioner agrees to be bound by the provisions in the medical staff Bylaws relating to immunity from liability for the participants in the hearing process.

7.5-11 GOVERNING BODY COMMITTEES

In the event the governing body should delegate some or all of its responsibilities described in this Article to one of its committees, the governing body shall nonetheless retain ultimate authority to accept, reject, modify or return for further action or hearing, the recommendation of its committee.

7.6 DECISION

7.6-1 GOVERNING BODY FINAL DECISION

Within 30 days after receipt of the appeal board report, or, if no appeal was requested, the hearing committee report, the governing body will render a final decision except as outlined in 7.6-2 and 7.6-3 below. The governing body shall affirm the decision of the hearing committee if the hearing committee's decision is supported by the bulk of evidence, following a fair procedure. The governing body will also consider the appeal board report.

7.6-2 GOVERNING BODY REVIEW OF COMMITTEE DECISION

Should the governing body determine that the hearing committee's decision is not supported by the bulk of evidence or that a fair procedure has not been afforded, the governing body may modify or reverse the decision of the hearing committee, or may remand the matter to the hearing committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the hearing committee for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the governing body. This further review and the time required to report back shall not exceed 30 days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the board of trustees and the hearing committee.

7.6-3 FINAL DECISION DISTRIBUTION

The decision shall be in writing, shall specify the reasons for the action taken, shall include the text of the report which shall be made to NPDB and the Nevada State Board of Medical Practitioners, if any, and shall be forwarded to the chief of staff, and the medical executive, the subject of the hearing, and the CEO, at least 10 days prior to submission to the NPDB and NSBMP.

7.7 EXCEPTIONS TO HEARING RIGHTS

7.7-1 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 6.3-1(a). In other cases described in Sections 6.3-1 and 6.3-2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority of the DEA was unwarranted, but only whether the member may continue practice in the hospital with those limitations imposed.

7.7-2 EXCLUSIVE CONTRACTS

Privileges can be reduced or terminated as a result of a decision to close or continue closure of a department/service pursuant to an exclusive contract, or to transfer an existing exclusive contract, only following review by the medical staff of the related quality of care issues pursuant to Section 13.9 and a determination of appropriateness of the closure, continued closure or transfer as set forth below. The governing body's decision shall uphold the medical staff's determination unless the governing board makes specific written findings that the medical staff's determination is arbitrary, capricious, and abuse of discretion, or otherwise not in accordance with the law. Any medical staff member whose privileges are reduced in this manor will not as a result of that action have a report sent to the NPDB or the Nevada State Board.

These Bylaws can not supersede the provisions of the contract. If there is a conflict the provision of the contract shall govern.

7.7-3 DEPARTMENT/SERVICE FORMATION OR ELIMINATION

A medical staff department/service can be formed or eliminated only following a review by the medical staff of the related quality of care issues.

(a) The medical staff member(s) whose privileges may be adversely affected by a medical staff's determination of appropriateness of department/service formation or elimination may request a hearing before the judicial review committee. Such a hearing will be governed by the provisions of Article VII, except that;

(1) the hearing shall be limited to the following issues;

(a) whether the medical staff's determination of appropriateness is supported by the preponderance of the evidence;

(b) whether the medical staff followed its requirements for notice and comment on the issue of appropriateness.

(2) all requests for such a hearing will be consolidated.

Should an effected medical staff member request a hearing under this subsection, the medical staff's recommendation regarding the department/service elimination or formation will be deferred, pending the outcome of the judicial review committee hearing.

(b) Except as specified in this Section, the termination of privileges pursuant to formation or elimination of a department/service determined to be appropriate by the medical staff shall not be subject to the procedural rights otherwise set forth in Article VII.

7.8 NATIONAL PRACTITIONER DATA BANK REPORTING

7.8-1 ADVERSE ACTIONS

The authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the description set forth in the final action as adopted by the governing body. The authorized representative shall report any and all revisions of an adverse action,

including, but not limited to, any expiration of the final action consistent with the terms of that final action.

7.9 ALLIED HEALTH PROFESSIONALS / SPECIFIED PROFESSIONAL PERSONNEL / ANCILLARY STAFF

Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an Allied Health Professional/Specified Professional Personnel/Ancillary Staff member to the procedural rights set forth in Article VII. However, an Allied Health Professional/Specified Professional Personnel member shall have the right to challenge any actions that would constitute grounds for a hearing under Section 7.2 of the Bylaws by filing a written grievance with the Medical Executive Committee within 15 days of such action. Upon receipt of such a grievance, the Medical Executive Committee or its designee shall conduct an investigation that shall afford the Allied Health Professional/Specified Professional Personnel/Ancillary Staff member an opportunity for an interview concerning the grievance. Any such interviews shall not constitute a "hearing" as established by Article 7 of the Bylaws and shall not be conducted according to the procedural rules applicable to such hearings. Before the interview, the Allied Health Professional/Specified Professional Personnel/Ancillary Staff member shall be informed of the general nature and circumstances giving rise to the action, and the Allied Health Professional/Specified Professional Personnel/Ancillary Staff member may present information relevant thereto at the interview. A record of the interview shall be made. The Medical Executive Committee or its designee shall make a decision based on the interview and all other information available to it.

ARTICLE VIII
OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1-1 IDENTIFICATION

The officers of the medical staff shall be the chief of staff, vice-chief of staff, immediate past chief of staff, secretary and two members-at-large.

8.1-2 QUALIFICATIONS

Officers must be members of the active medical staff at the time of their nominations and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

Officers shall:

a) Understand the purpose and the function of the medical staff and demonstrate willingness to ensure that patient welfare always takes precedence over other concerns;

b) Understand and be willing to work toward maintaining the hospital's compliance with lawful and reasonable policies and requirements;

c) Demonstrate administrative capability, as applicable to the respective office;

d) Be able to work with and motivate others to achieve the objectives of the medical staff and hospital;

e) Demonstrate clinical competence in his or her field of practice; and

f) Demonstrate no significant conflicts of interest.

8.1-3 NOMINATIONS

The medical staff election year shall be each medical staff year. A nominating committee shall be appointed by the medical executive committee no later than forty-five (45) days prior to the annual staff meeting to be held during the election year or at least thirty (30) days prior to any special election. The nominating committee shall nominate one or more nominees for secretary and member-at-large. Fourteen (14) days prior to the election a ballot will be sent out to the voting members of the medical staff.

Forty-five (45) days prior to the election nominations may be made to the nominating committee by any member of the medical staff. Nominations must be received at least 30 days prior to the election.

8.1-4 ELECTIONS

The secretary and member-at-large shall be elected at the annual meeting of the medical staff. Voting shall be by secret written ballot, and authenticated sealed mail ballots may be counted. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held immediately between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the medical executive committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

8.1-5 TERM OF ELECTED OFFICE

Each officer shall serve a one (1) year term, commencing on the first day of the medical staff year following the election. The members-at-large shall be elected to two year alternate terms such that one new member will be elected each year. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall resign or be removed from office. At the end of that officer's term, the chief of staff shall automatically assume the office of immediate past chief of staff, the vice-chief of staff shall automatically assume the office of chief of staff and the secretary shall automatically assume the office of the vice-chief of staff.

8.1-6 RECALL OF OFFICERS

Any officer whose election is subject to these Bylaws may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office. Recall of a medical staff officer may be initiated by the medical executive committee or shall be initiated by a petition signed by at least one-third (1/3) of the members of the medical staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds (2/3) vote of the medical staff members eligible to vote for medical staff officers who actually cast votes at the special meeting in person or by mail ballot.

8.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies, other than that of the chief of staff, shall be filled by appointment by the medical executive committee until the next regular election. If there is a vacancy in the office of chief of staff, then the vice-chief of staff shall serve out that remaining term and shall immediately appoint an ad hoc nominating committee to decide promptly upon nominees for the office of vice-chief of staff. Such nominees shall be reported to the medical executive committee and to the medical staff. A special election to fill the position shall occur at the next regular staff meeting. If there is a vacancy in the office of vice-chief of staff, that office need not be filled by election, but the medical executive committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of chief of staff.

8.2 DUTIES OF OFFICERS

8.2-1 CHIEF OF STAFF

The chief of staff shall serve as the chief officer of the medical staff. The duties of the chief of staff shall include, but not be limited to:

(a) Enforcing the medical staff Bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

(b) Calling, voting, presiding at, and being responsible for the agenda of all meetings of the general medical staff;

(c) Serving as chair of the executive committee;

(d) Serving as an ex officio member of all other staff committees without vote, unless chief of staff membership in a particular committee is required by these Bylaws;

(e) Interacting with the administrator and governing body in all matters of mutual concern within the hospital; and represent the medical staff as a member of the Governing Board.

(f) Appointing, in consultation with the medical executive committee, committee members for all standing and special medical staff, liaison, or multi-disciplinary committees, except where otherwise provided by these ByLaws and, except where otherwise indicated, designating the chairs of these committees;

(g) Representing the views and policies of the medical staff to the governing body and to the administrator;

(h) Being a spokesperson for the medical staff in external professional and public relations;

(I) Performing such other functions as may be assigned to the chief of staff by these Bylaws, the medical staff, or by the medical executive committee; and

(j) Serving on liaison committees with the board of trustees and administration, as well as outside licensing or accreditation agencies.

8.2-2 VICE-CHIEF OF STAFF

The vice-chief of staff shall assume all duties and authority of the chief of staff in the absence of the chief of staff. The vice-chief of staff shall be a member of the medical executive committee and of the joint conference committee, and shall perform such

other duties as the chief of staff may assign or as may be delegated by these Bylaws or by the medical executive committee.

8.2-3 IMMEDIATE PAST CHIEF OF STAFF

The immediate past chief of staff shall be a member of the medical executive committee and a member of the joint conference committee and shall perform such other duties as may be assigned by the chief of staff or delegated by these Bylaws, or by the medical executive committee.

8.2-4 SECRETARY

The secretary shall be a member of the executive committee. The duties shall include, but not be limited to:

(a) Maintaining a roster of members;

(b) Cause to be kept accurate and complete minutes of all medical executive committee and general medical staff meetings;

(c) Calling meetings on the order of the chief of staff or medical executive committee;

(d) Attending to all appropriate correspondence and notices on behalf of the medical staff;

(e) Receiving and safeguarding all funds of the medical staff;

(f) Excusing absences from meetings on behalf of the medical executive committee; and

(g) Performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the chief of staff or medical executive committee.

ARTICLE IX
CLINICAL DEPARTMENTS AND DIVISIONS

9.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS

The medical staff shall be divided into clinical departments. Each department shall be organized as a separate component of the medical staff and shall have a chair selected and

entrusted with the authority, duties, and responsibilities specified in Section 9.6. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which it functions, and which shall have a division chief selected and entrusted with the authority, duties and responsibilities specified in Section 9.5. When appropriate, the medical executive committee may recommend to the medical staff the creation, elimination, modification, or combination of departments or divisions.

9.2 CURRENT DEPARTMENTS AND DIVISIONS

The current departments are, Medicine, Surgery, OB/GYN, Pediatrics, Emergency and Radiology. The current divisions are as delineated in the Rules & Regulations.

9.3 ASSIGNMENT TO DEPARTMENTS and DIVISIONS

Each member shall be assigned membership in at least one department, and to a division, if any, within such department, but may also be granted membership and/or clinical privileges in other departments or divisions consistent with practice privileges granted. The exercise of clinical privileges within any department is subject to the rules and regulations of that department and to the authority of the department chair.

9.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

(a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The number of such reviews to be conducted during the year shall be as determined by the medical executive committee in consultation with other appropriate committees. The department shall routinely collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department.

(b) Recommending to the medical executive committee guidelines for the granting of clinical privileges and the performance of specified services within the department.

(c) Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department.

(d) Conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice;

(e) Reviewing and evaluating departmental adherence to: (1) medical staff policies and procedures; and (2) sound principles of clinical practice;

(f) Coordinating patient care provided by the department's members with nursing and ancillary patient care services;

(g) Submitting written reports to the medical executive committee concerning: (1) the department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendation for maintaining and improving the quality of care provided in the department and the hospital;

(h) Meeting at least quarterly for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other departments and staff functions;

(i) Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including Focused Professional Performance Evaluation protocols;

(j) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;

(k) Accounting to the medical executive committee for all professional and medical staff administrative activities within the department;

(l) Formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval of the medical executive committee and the medical staff;

(m) Conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services; and

(n) Review of surgical cases in which a specimen (tissue or non-tissue) is removed, as well as from those cases in which no specimen is removed. The review shall include the indications for surgery and all cases in which there is a major discrepancy between the pre-operative and post-operative diagnosis.

9.5 FUNCTIONS OF DIVISIONS

Subject to approval of the medical executive committee, each division shall perform the functions assigned to it by the department chair. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review and privileges delineation, and continuing education programs. The division shall transmit regular reports to the department chair on the conduct of its assigned functions.

9.6 DEPARTMENT HEADS

9.6-1 QUALIFICATIONS

Each department shall have a chair who shall be a member of the active medical staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the department. Department chairs must be certified by an appropriate specialty board or must demonstrate comparable competence. Comparable competence is defined as having completed a residency in their specialty and/or the individual is currently practicing in that specialty as a member in good standing of that department.

9.6-2 SELECTION

Department chairs shall be elected by department members and approved by the Chief of Staff. Department chairs will serve on the Medical Executive Committee. Vacancies, due to any reason, shall be filled for the unexposed term through special appointment by the chief of staff.

9.6-3 TERM OF OFFICE

Each department chair shall serve a one (1) year term which coincides with the medical staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their medical staff membership or clinical privileges in that department. Department chairs shall be eligible to succeed themselves.

9.6-4 REMOVAL

Removal of department chairs from office may occur by a two-thirds (2/3) vote of the medical executive committee and a two-thirds (2/3) vote of the department members eligible to vote on departmental matters who cast votes.

9.6-5 DUTIES

Each chair shall have the following authority, duties and responsibilities:

(a) Act as presiding officer at departmental meetings;

(b) Report to the medical executive committee and to the chief of staff regarding all professional and administrative activities within the department;

(c) Generally monitor the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the medical executive committee;

(d) Develop and implement departmental programs for retrospective patient care review, on-going monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assurance.

(e) May be invited to attend at the request of a member of the medical executive committee, to give guidance on the overall medical policies of the medical staff and hospital and make specific recommendations and suggestions regarding the department;

(f) Transmit to the medical executive committee the department's recommendations concerning practitioner appointment and classification, reappointment, clinical privileges; criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the department;

(g) Endeavor to enforce the medical staff Bylaws, rules, policies and regulations within the department;

(h) Implement within the department appropriate actions taken by the medical executive committee;

(i) Participate in every phase of administration of the department, including cooperation with the nursing service and the hospital administration in matters such as personnel (staffing standards), (including assisting in determining the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide patient care services) supplies, special regulations, standing orders and techniques;

(j) Assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the medical executive committee;

(k) Recommend delineated clinical privileges for each member of the department;

(l) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the chief of staff or the medical executive committee; and

(m) Conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services.

(n) When necessary, assessing and recommending to the medical executive committee off-site sources for needed patient care services not provided by the department or the hospital;

(o) Ensuring the integration of the department into the vision statement of the hospital;

(p) When necessary, coordinating and integrating interdepartmental and intra-departmental services;

(q) Recommending to the medical executive committee a sufficient number of qualified and competent persons to provide care or services within the department;

(r) Coordinating and monitoring the orientation and continuing education of all persons in the department;

(s) Communicating to the medical executive committee the need for space and other resources needed by the department, and;

(t) Ensure that all individuals within the department that have clinical privileges only provide services within the scope of privileges granted. Provide for continual surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

(u) Maintain quality control programs within the department as appropriate.

ARTICLE X
COMMITTEES

10.1 DESIGNATION

Medical staff committees shall include but not be limited to, the medical staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under this Article, and meetings of special or ad hoc committees created by the medical executive committee (pursuant to this Section) or by departments (pursuant to Sections 9.4 (I) and (l)). The committees described in this Article shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the medical executive committee to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the chief of staff, subject to consultation with and approval by the medical executive committee. Medical staff committees shall be responsible to the medical executive committee.

10.2 GENERAL PROVISIONS

10.2-1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of one (1) year, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

10.2-2 REMOVAL

If a member of a committee ceases to be a member in good standing of the medical staff, or loses employment or a contract relationship with the hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the medical executive committee. Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the medical executive committee.

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

The medical executive committee shall consist of the following persons:

(a) The chief of staff; (only the chief of staff may not simultaneously hold office as the chief of a department while serving on the Medical Executive Committee.)

(b) The vice-chief of staff;

(c) The secretary of staff;

(d) The past chief of staff;

(e) The chief executive officer, as ex-officio member without vote; and

(f) Two members-at-large.

(g) Department Chairs.

10.3-2 DUTIES

The duties of the medical executive committee shall include, but not be limited to:

(a) Representing and acting on behalf of the medical staff in the intervals between medical staff meetings, subject to such limitations as may be imposed by these Bylaws;

(b) Providing a mechanism for effective communication among the medical staff, hospital administration and governing body.

(c) Coordinating and implementing the professional and organizational activities and policies of the medical staff;

(d) Receiving and acting upon reports and recommendations from medical staff departments, divisions, committees, and assigned activity groups;

(e) Presenting medical staff recommendations directly to the governing body for its approval.

(f) Establishing the structure of the medical staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities and mechanisms of the medical staff, termination of medical staff membership and fair hearing procedures, as well as, other matters relevant to the operation of an organized medical staff;

(g) Evaluating the medical care rendered to patients in the hospital;

(h) Participating in the development of all medical staff and hospital policy, practice, and planning by chief of staff attending regularly scheduled governing body meeting;

(i) Reviewing the qualifications, credentials, professional behavior, conduct, performance and professional competence, and character of applicant and staff members, and making recommendations to the governing body regarding staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;

(j) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in medical staff corrective or review measures when warranted;

(k) Taking reasonable steps to develop continuing education activities and programs for the medical staff;

(l) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the medical staff and approving or rejecting appointments to those committees by the chief of staff;

(m) Reporting to the medical staff at each regular staff meeting;

(n) Assisting in obtaining and maintenance of accreditation;

(o) Developing and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;

(p) Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the medical executive committee in carrying out its functions and those of the medical staff;

(q) Reviewing the quality and appropriateness of services, including patient safety and patient satisfaction, provided by all members of the medical staff.

(r) Reviewing and approving the designation of the hospital's authorized representative for National Practitioner Data Bank purposes; and

(s) Establishing a mechanism for dispute resolution between medical staff members (including limited license practitioners) involving the care of a patient.

(t) Make recommendations directly to the governing body on medical staff membership and medical staff membership termination.

(u) The Medical Executive Committee reviews and acts on reports of medical staff committees, departments and other assigned activity groups.

10.3-3 MEETINGS

The executive committee shall meet as often as necessary, but at least once every six (6) weeks and shall maintain a record of its proceedings and actions.

10.4 CREDENTIALS COMMITTEE

10.4-1 COMPOSITION

The Credentials Committee shall consist of not less than four (4) members of the active staff selected on a basis that will ensure, insofar as feasible, representation of major clinical specialties and each of the staff departments. The Vice Chief of Staff will serve as chairman of the Credentials Committee.

10.4-2 DUTIES

The Credentials Committee shall:

(a) Review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment, or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendation of the appropriate departments;

(b) Submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, department affiliation, clinical privileges, and special conditions;

(c) Investigate, review and report on matters referred by the chief of staff or medical executive committee regarding the qualifications, conduct, professional character, or competence of any applicant or medical staff member; and

(d) Submit periodic reports to the medical executive committee on its activities and status of pending applications.

10.4-3 MEETINGS

The Credentials Committee shall meet as often as necessary at the call of its chair. The Committee shall maintain a record of its proceedings and actions and shall report to the medical executive committee.

10.5 JOINT CONFERENCE COMMITTEE

10.5-1 COMPOSITION

The joint conference committee shall be composed of an equal number of members of the governing body and of the medical executive committee, but the medical staff members shall at least include the chief of staff, the vice-chief of staff, and the immediate past chief of staff. The administrator shall be a non-voting ex-officio member. The chairmanship of the committee shall alternate yearly between the governing body and the medical staff.

10.5-2 DUTIES

The joint conference committee shall constitute a forum for discussion of matters of hospital and medical staff policy, practice and planning, and a forum for interaction between the governing body and the medical staff on such matters as may be referred by the medical executive committee or the governing body. The joint conference committee shall exercise other responsibilities as set forth in these Bylaws.

10.5-3 MEETINGS

The joint conference committee shall meet as necessary at the call of the Governing Board Chair or the Chief of Staff, and shall transmit written reports of its activities to the general medical staff and to the governing body.

10.6 MEDICAL RECORDS COMMITTEE

10.6-1 COMPOSITION

The medical records committee may consist of at least one representative from each clinical department, the nursing service, the medical records department, and hospital administration

10.6-2 DUTIES

The duties of the medical records committee shall include:

(a) Review and evaluation of medical records, or a representative sample, to determine whether they: (1) properly describe the condition and diagnosis,

the progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided, the results thereof, and adequate identification of individuals responsible for orders given and treatment rendered; and (2) are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the hospital;

(b) Review and make recommendations for medical staff and hospital policies, rules and regulations relating to medical records, including completion, forms and formats, filing, indexing, storage, destruction, availability and methods of enforcement;

(c) Provide liaison with hospital administration and medical records personnel in the employ of the hospital on matters relating to medical records practices; and

(d) Maintain a record of all actions taken and submit periodic reports to the medical executive committee concerning medical record practices in the hospital.

10.6-3 MEETINGS

The medical records committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a permanent record of its proceedings and activities, and shall report to the medical executive committee.

10.7 PHARMACY AND THERAPEUTICS COMMITTEE

10.7-1 COMPOSITION

The pharmacy and therapeutics committee shall consist of at least two (2) representatives from the medical staff, a voting representative from the pharmaceutical service, and a non-voting representative from the nursing service and hospital administration.

10.7-2 DUTIES

The duties of the pharmacy and therapeutics committee shall include:

(a) Assisting in the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;

(b) Advising the medical staff and the pharmaceutical service on matters pertaining to the choice of available drugs;

(c) Making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(d) Periodically developing and reviewing a formulary or drug list for use in the hospital.

(e) Evaluating clinical data concerning new drugs or preparations requested for use in the hospital;

(f) Establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

(g) Maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the special committee concerning those activities;

(h) Developing proposed policies and procedures for the screening, distribution, handling and administration of blood and blood components; and

(I) Reviewing untoward drug reactions.

10.7-3 MEETINGS

The committee shall meet as often as necessary at the call of its chair but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the medical executive committee.

10.8 INFECTION CONTROL COMMITTEE

10.8-1 COMPOSITION

The infection control committee shall consist of at least two (2) members. Eligible representatives would be from the departments of medicine, surgery, pathology, nursing service, administration, and an individual employed in a surveillance or epidemiological capacity. It may include non-voting consultants in microbiology and non-voting representatives from relevant hospital services.

10.8-2 DUTIES

The duties of the infection control committee shall include:

(a) Developing a hospital-wide infection control program and maintaining surveillance over the program;

(b) Developing a system of reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;

(c) Developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

(d) Developing written policies defining special indications for isolation requirements;

(e) Coordinating action on findings from the medical staff's review of the clinical use of antibiotics;

(f) Acting upon recommendations related to infection control received from the chief of staff, the medical executive committee, departments and other committees; and

(g) Reviewing sensitivities of organisms specific to the facility.

10.8-3 MEETINGS

The infection control committee shall meet as often as necessary at the call of its chair but at least once quarterly. It shall maintain a record of its proceedings and shall submit reports of its activities and recommendations to the medical executive committee.

10.9 BYLAWS COMMITTEE

10.9-1 COMPOSITION

The Bylaws committee shall consist of at least three (3) members of the medical staff, as appointed by the chief of staff. The administrator may attend the meetings without vote to provide research material, administrative support, and general guidance.

10.9-2 DUTIES

The duties of the Bylaws committee shall include:

(a) Conducting a biannual review of the medical staff Bylaws, as well as the rules and regulations and forms promulgated by the medical staff, its departments and divisions;

(b) Submitting recommendations to the medical executive committee for changes in these documents as necessary to reflect current medical staff practices; and

(c) Receiving and evaluating of recommendation to the medical executive committee suggestions for modification of the items specified in subdivision (a).

10.9-3 MEETINGS

The Bylaws committee shall meet as often as necessary at the call of its chair but at least biannually. It shall maintain a record of its proceedings and shall report its activities and recommendations to the medical executive committee.

10.10 UTILIZATION MANAGEMENT COMMITTEE

10.10-1 COMPOSITION

The Utilization Management Committee shall consist of such members as may be designated by the medical executive committee including, insofar as possible, at least one representative from each clinical department, from the nursing service and from administration. The utilization review coordinator and case manager shall be members of the Utilization Management Committee.

10.10-2 DUTIES

The utilization management committee shall perform the following duties:

(a) Functions as the peer review committee of the Medical Staff and reports directly to the Medical Executive Committee. The Chief of Staff reports Utilization Management Committee activities to the Governing Board.
(b) Peer review of medical staff charts that fail to meet the quality criteria developed and approved by members of the medical staff.
(c) Review of charts that fail to meet utilization criteria as established by InterQual and/or Medicare/Medicaid and other insurance carriers.

(d) Peer review of charts that do not meet professionally recognized quality standards.
(e) Peer review of charts that do not meet medical necessity for treatment of patients.
(f) Annual review, evaluation and approval of the Utilization Management Plan.

10.10-3 MEETINGS

The committee shall meet monthly. It shall maintain a record of its proceedings and report its activities and recommendations to the medical executive committee and governing body, except that routine reports to the board shall not include peer evaluations related to individual members.

10.10-4 MEDICAL RECORDS COMMITTEE

The Committee shall meet at least quarterly or as needed and determined by the Chair of the Utilization Management Committee. The Committee will report at least quarterly to the Utilization Management Committee. The Chief of the Utilization Management Committee will preside over the Medical Records Committee.

10.11 MEDICAL STAFF AID COMMITTEE

10.11-1 COMPOSITION

In order to improve the quality of care and promote the competence of the medical staff, the medical executive committee shall establish a medical staff aid committee comprised of no less than two (2) active members of the medical staff, a majority of which, including the chair, shall be physicians. Except for initial appointments, each member shall serve a term of one (1) year, and the terms shall be staggered as deemed appropriate by the executive committee to achieve continuity. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assurance committees while serving on this committee.

10.11-2 DUTIES

The medical staff aid committee may receive reports related to the health, well-being, or impairment of medical staff members, Allied Health Professionals, Specified Professional Personnel, Ancillary staff and, as it deems appropriate, may investigate such reports. With respect to matters involving individual medical staff, allied health professionals, specified professional personnel, or ancillary staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known

impairment of a medical staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action. The committee shall also consider general matters related to health and well being of the medical staff and, with the approval of the executive committee, develop educational programs or related activities. Each member of the medical staff, allied health professional staff specified professional personnel or ancillary staff shall be afforded the opportunity of self referral.

10.11-3 MEETINGS

The committee shall meet as often as necessary but at least yearly.. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities on a routine basis to the medical executive committee.

10.11-4 REPORT AND INVESTIGATION

If any individual working in the hospital has a reasonable suspicion that a physician appointed to the medical staff, allied health professional, specified professional personnel, or ancillary staff member is impaired, the following steps shall be taken:

1. A verbal or, preferably, a written report shall be given to the Chief Executive Officer or the Chief of Staff. The report shall include a description of the incident(s) that led to the belief that the physician may be impaired.
   The report must be factual. The individual making the report need not have proof of impairment, but must state the facts leading to the suspicions. Impairment, as used in this policy, includes both physical and mental impairment, as well as impairment due to drugs or alcohol.

2. If, after discussing the incidents with the individual who filed the report, the Chief Executive Officer and Chief of Staff believe there is sufficient information to warrant further investigation, the Chief Executive Officer and Chief of Staff may:

   a) meet personally with the physician, allied health professional, specified professional personnel, or ancillary staff member or designate another appropriate person to do so; and/or

   b) direct in writing that an investigation be instituted and a report thereof be rendered by the Medical Executive Committee.

3. In performing all functions hereunder, the Chief Executive Officer and Chief of Staff shall be deemed authorized agents of the Medical Executive Committee and shall enjoy all immunity and confidentiality protections afforded under state and federal law.

4. Following a written request to investigate, the Medical Executive Committee shall investigate the concerns and any and all incidents that led to the belief that the physician, allied health professional, specified professional personnel, or ancillary staff member may be impaired. The Medical Executive Committee's investigation may include, but is not limited to, any of the following:

   a) a review of any and all documents or other materials relevant to the investigation;
   b) interviews with any and all individuals involved in the incidents or who may have information relevant to the investigation, provided that any specific inquiries made regarding the physician's health status are related to the performance of the physician's, allied health professional, specified professional personnel, or ancillary staff member clinical privileges and medical staff duties and are consistent with proper patient care or effective operation of the hospital.
   c) a requirement that the physician, allied health professional, specified professional personnel, or ancillary staff member undergo a complete medical examination as directed by the Medical Executive Committee, so long as the exam is related to the performance of the physician's clinical privileges and medical staff duties and is consistent with proper patient care or the effective operation of the hospital.
   d) a requirement that the physician, allied health professional, specified professional personnel, or ancillary staff member take a drug test to determine if the physician is currently using drugs illegally.

5. The Medical Executive Committee shall meet informally with the physician, allied health professional, specified professional personnel, or ancillary staff member as part of its investigation. This meeting does not constitute a hearing under the due process provisions of the hospital's medical staff bylaws or pertinent credentialing policy. At this meeting, the Committee may ask the physician, allied health professional, specified professional personnel, or ancillary staff member health-related questions so long as they are related to the performance of the physician's, allied health professional, specified professional personnel, or ancillary staff member clinical privileges and medical staff duties, and are consistent with proper patient care and the effective operation of the hospital. In addition, the Committee may discuss with the physician, allied health professional, specified professional personnel, or ancillary staff member whether a reasonable accommodation is needed or could be made so that the physician, allied health professional, specified professional personnel, or ancillary staff member could competently and safely exercise his or her

clinical privileges and the duties and responsibilities of medical staff appointment.

6. Based on all the information it reviews as part of its investigation, the Medical Executive Committee shall determine:

   a) whether the physician, allied health professional, specified professional personnel, or ancillary staff member is impaired, or what other problem, if any, is affecting the physician; allied health professional, specified professional personnel, or ancillary staff member
   b) if the physician, allied health professional, specified professional personnel, or ancillary staff member is impaired, the nature of the impairment and whether it is classified as a disability under the ADA;
   c) if the physician's, allied health professional, specified professional personnel, or ancillary staff member's impairment is a disability, whether a reasonable accommodation can be made for the physician's allied health professional, specified professional personnel, or ancillary staff member impairment such that, with the reasonable accommodation, the physician, allied health professional, specified professional personnel, or ancillary staff member would be able to competently and safely perform his or her clinical privileges and the duties and responsibilities of medical staff appointment;
   d) whether a reasonable accommodation would create an undue hardship upon the hospital, such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the hospital's operations or the provision of patient care; and
   e) whether the impairment constitutes a "direct threat" to the health or safety of the physician, allied health professional, specified professional personnel, or ancillary staff member, patients, hospital employees, physicians or others within the hospital. A direct threat must involve a significant risk of substantial harm based upon medical analysis and/or other objective evidence. If the physician appears to pose a direct threat because of a disability, the Committee must also determine whether it is possible to eliminate or reduce the risk to an acceptable level with a reasonable accommodation.

7. If the Medical Executive Committee determines that there is a reasonable accommodation that can be made as described above, the Committee shall attempt to work out a voluntary agreement with the physician, allied health professional, specified professional personnel, or ancillary staff member so long as that arrangement would neither constitute an undue

hardship upon the hospital or create a direct threat, also as described above. The Chief Executive Officer and Chief of Staff shall be kept informed of attempts to work out a voluntary agreement between the Committee and the physician, allied health professional, specified professional personnel or ancillary staff member and shall approve any agreement before it becomes final and effective.

8. If the Medical Executive Committee determines that there is no reasonable accommodation that can be made as described above, or if the Medical Executive Committee cannot reach a voluntary agreement with the physician, allied health professional, specified professional personnel, or ancillary staff member the Medical Executive Committee shall make a recommendation and report to the Governing Board, through the Chief Executive Officer, as to appropriate action to be taken. If the Committee's recommendation would provide the physician with a right to a hearing as described in the hospital's medical staff bylaws or credentialing policy the Medical Executive Committee shall then make a recommendation pursuant to the Bylaws and Fair Hearing Plan. The Chief Executive Officer shall promptly notify the physician allied health professional, specified professional personnel, or ancillary staff member of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Governing Board until the individual has exercised or has been deemed to have waived the right to a hearing as provided in the hospital's medical staff bylaws or credentialing policy.

9. The original report and a description of the actions taken by the Chief Executive Officer or the Medical Executive Committee shall be included in the physician's allied health professional, specified professional personnel, or ancillary staff member's confidential file. If the initial or follow-up investigation reveals that there is no merit to the report, the report shall be destroyed. If the initial or follow-up investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a separate portion of the physician's allied health professional, specified professional personnel, or ancillary staff member's file and the physician's allied health professional, specified professional personnel, or ancillary staff member's activities and practice shall be monitored until it can be established that there is, or is not, an impairment problem.

10. The Chief Executive Officer shall inform the individual who filed the report that follow-up action was taken, but shall not disclose confidential peer review information or specific actions implemented.

11. Throughout the process, all parties shall avoid speculation, conclusions, gossip, and any discussions of this matter with anyone outside those described above.

10.11-5 REHABILITATION AND REINSTATEMENT GUIDELINES:

If it is determined that the physician, allied health professional, specified professional personnel, or ancillary staff member suffers from an impairment that could be reasonably accommodated through rehabilitation, the following are guidelines for rehabilitation and reinstatement:

1. Hospital and medical staff leadership shall assist the physician, allied health professional, specified professional personnel, or ancillary staff member in locating a suitable rehabilitation program. A physician, allied health professional, specified professional personnel, or ancillary staff member shall not be reinstated until it is established, to the hospital's satisfaction, that the physician allied health professional, specified professional personnel, or ancillary staff member has successfully completed a program in which the hospital has confidence.

2. Upon sufficient proof that a physician, allied health professional, specified professional personnel, or ancillary staff member who has been found to be suffering from impairment has successfully completed a rehabilitation program, the hospital, in its discretion, may consider that physician for reinstatement to the medical staff.

3. In considering an impaired physician, allied health professional, specified professional personnel, or ancillary staff member for reinstatement, the hospital and medical staff leadership must consider patient care interests paramount.

4. The hospital must first obtain a letter from the physician director of the rehabilitation program where the physician, allied health professional, specified professional personnel, or ancillary staff member was treated. The physician must authorize the release of this information. That letter shall state:

    a) whether the physician, allied health professional, specified professional personnel, or ancillary staff member is participating in the program;

b) whether the physician, allied health professional, specified professional personnel, or ancillary staff member is in compliance with all of the terms of the program;
c) to what extent the physician's, allied health professional, specified professional personnel, or ancillary staff member's behavior and conduct are monitored;
d) whether, in the opinion of the director, the physician, allied health professional, specified professional personnel, or ancillary staff member is rehabilitated;
e) whether an after-care program has been recommended to the physician, allied health professional, specified professional personnel, or ancillary staff member and, if so, a description of the after-care program; and
f) whether, in the director's opinion, the physician, allied health professional, specified professional personnel, or ancillary staff member is capable of resuming medical practice and providing continuous, competent care to patients.

5. The physician, allied health professional, specified professional personnel, or ancillary staff member must inform the hospital of the name and address of his or her primary care physician, and must authorize that physician to provide the hospital with information regarding his or her condition and treatment. The hospital has the right to require an opinion from other physician consultants of its choice.

6. From the primary care physician the hospital needs to know the precise nature of the physician's, allied health professional, specified professional personnel, or ancillary staff member's condition, and the course of treatment as well as the answers to the questions posed in (4)(e) and (g).

7. Assuming all of the information received indicates that the physician, allied health professional, specified professional personnel, or ancillary staff member is rehabilitated and capable of resuming care of patients, the hospital shall take the following additional precautions when restoring clinical privileges:

a) the physician, allied health professional, specified professional personnel, or ancillary staff member must identify a physician who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability;
b) the physician, allied health professional, specified professional personnel, or ancillary staff member shall be required to obtain periodic reports for the hospital from his or her primary physicians

for a period of time specified by the Chief of Staff and Chief Executive Officer, stating that the physician, allied health professional, specified professional personnel, or ancillary staff member is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired.

8. The physician's, allied health professional, specified professional personnel, or ancillary staff member's exercise of clinical privileges in the hospital shall be monitored by the department chairperson or by a physician appointed by the department chairperson. The nature of that monitoring shall be determined by the Medical Executive Committee after its review of all of the circumstances.

9. The physician, allied health professional, specified professional personnel, or ancillary staff member must agree to submit to an alcohol or drug screening test (if appropriate to the impairment) at the request of the Chief Executive Officer, Chief of Staff, or the pertinent department chair.

10. All requests for information concerning the impaired physician shall be forwarded to the Chief Executive Officer or Chief of Staff for response.

11. When a licensed independent practitioner fails to complete the required rehabilitation the Medical Executive Committee shall make a recommendation and report to the Governing Board, through the Chief Executive Officer, as to appropriate action to be taken. If the Committee's recommendation would provide the physician with a right to a hearing as described in the hospital's medical staff bylaws or credentialing policy the Medical Executive Committee shall then make a recommendation pursuant to the Bylaws and Fair Hearing Plan. The Chief Executive Officer shall promptly notify the Individual staff member of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Governing Board until the individual has exercised or has been deemed to have waived the right to a hearing as provided in the hospital's medical staff bylaws or credentialing policy.

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10.12 BIOETHICS COMMITTEE

10.12-1 COMPOSITION

The bioethics committee shall consist of physicians and such other staff members as the medical executive committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicist, attorneys, administrators and representatives from the governing body, although a majority shall be physician members of the medical staff.

10.12-2 DUTIES

The bioethics committee may participate in development of guidelines of reconsideration of cases having bioethical implications; development and implementation of procedures of the review of such cases; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases of the evaluation of bioethical policies; consultation with concerned parties to facilitate communication and aid conflict resolution; and education of the hospital staff on bioethical matters

10.12-3 MEETINGS

The committee shall meet as often as necessary, but at least yearly, at the call of its chair. It shall maintain a record of its activities and report to the medical executive committee.

ARTICLE XI
MEETINGS

11.1 MEETINGS

11.1-1 ANNUAL MEETINGS

There shall be an annual meeting of the medical staff to be held in December. The chief of staff, or such other officers, department or division heads, or committee chairs the chief of staff or medical executive committee may designate, may present reports on actions taken during the preceding year and on other matters of interest and importance to the members. Notice of this meeting shall be given to the members at least fourteen (14) days prior to the meeting.

11.1-2 REGULAR MEETINGS

Regular meetings of the members shall be held at least yearly in December, The date, place and time of the regular meeting shall be determined by the medical executive committee, and adequate notice shall be given to the members.

11.1-3 AGENDA

The order of business at a meeting of the medical staff shall be determined by the chief of staff and medical executive committee. The agenda shall include, insofar as feasible or applicable:

(a) Reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) Administrative reports from the chief of staff, departments, and committees, and the administrator;

(c) Election of officers when required by these ByLaws;

(d) Reports by responsible officers, committees and departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of other required staff functions.

(e) Old business; and

(f) New business.

11.1-4 SPECIAL MEETINGS

Special meetings of the medical staff may be called at any time by the chief of staff or the medical executive committee or shall be called upon the written request of twenty (20%) of the members of the active medical staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the medical executive committee within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the members of the staff, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

11.2 COMMITTEE AND DEPARTMENT MEETINGS

11.2-1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the chairs of committees, departments and divisions may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

11.2-2 SPECIAL MEETINGS

A special meeting of any medical staff committee or department may be called by the chair thereof, the medical executive committee, or the chief of staff, and shall be called by written request of [one-third] of the current members, eligible to vote, but not less than two (2) members.

11.3 QUORUM

11.3-1 STAFF MEETINGS

The presence of two-thirds (2/3) of the total members of the active medical staff at any regular or special meeting in person or through written ballot shall constitute a quorum for the purpose of amending these Bylaws or the rules and regulations of the medical staff for the election or removal of medical staff officers. The presence of thirty (30%) percent of such members shall constitute a quorum for all other actions.

11.3-2 DEPARTMENT AND COMMITTEE MEMBERS

The presence of one voting member will constitute a quorum for regularly scheduled committee meetings. A quorum of 50% of voting members will be required at special meetings.

11.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group.

11.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the medical executive committee.

11.6 ATTENDANCE REQUIREMENTS

11.6-1 REGULAR ATTENDANCE

Each member of the Active and Provisional Medical Staff may attend meetings of committees to which they are assigned.

Each member of the consulting or courtesy staff and members of the provisional staff who qualify under criteria applicable to courtesy or consulting members shall be required to attend such meetings as may be determined by the Medical Executive Committee. Pendency members must attend all meetings to which they are assigned. Locum Tenens members of the medical staff under section 5.5-1 are excluded from meeting requirements.

11.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to [Robert's Rules of Order;] however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

11.8 EXECUTIVE SESSION

Executive session is a meeting of a medical staff committee which only voting medical staff committee members may attend, unless others are expressly requested by the committee to attend. The administrator or Governing Board Chair may be allowed to attend at the discretion of the Committee Chair. Executive session may be called by the presiding officer at the request of any medical staff committee member, and shall be called by the presiding officer pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

ARTICLE XII
CONFIDENTIALITY, IMMUNITY AND RELEASES

12.1 CONFIDENTIALITY OF INFORMATION

12.1-1 GENERAL

Medical staff, department, section or committee minutes, files and records, including applications and information regarding any member or applicant to this medical staff shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the medical staff committee files and shall not become part of any particular patient's file or of the general Hospital records. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the medical staff or, where no officially adopted policy exists, only with the express approval of the chief of staff and chief executive officer.

No physician is to view another physician's records unless it is in regards to him treating the patient, or for peer review as requested by the chief of staff or chief of the department.

12.1-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff departments or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this medical staff and will be deemed disruptive to the operations of the hospital. If it is determined that such a breach has occurred, the medical executive committee may undertake such corrective action as it deems appropriate.

12.1-3 FREEDOM OF INFORMATION

Each past and present member of the Medical Staff shall, upon request, be promptly informed of:

a) he existence of any files, records or documents of a professional or personal nature pertaining to said member in the possession of or available to the Governing Body or Administration or the Medical Staff; and

b) the entry of any negative or derogatory information into said files, records or documents.

Said member may review all information in such files, records or documents, and append responses when desired. Confidential incident reports may be reviewed (and responses appended) by a member, upon request, if the Medical Executive Committee or Governing Board initiates an investigation or corrective action against the member. Except as provided by law, release of any information contained in such files, records, or documents shall require the signed consent of said member. Such files may, however, be used during the hospital's confidential peer review process.

12.1-4 RIGHT TO QUESTION

Each past and present member of the Medical Staff has the right to challenge any rule, regulations, policy, recommendation or action, except an adverse action against a member approved by the Medical Executive Committee through a supporting petition signed by fifteen percent (15%) of the Medical Staff members. Upon receipt

of such a petition, the Chief of Staff shall place on the agenda of the next regular Medical Executive Committee meeting or schedule a special meeting of the Medical Executive Committee to discuss the issue and invite the representative(s) of the petitioning members.

12.2 IMMUNITY FROM LIABILITY

12.2-1 FOR ACTION TAKEN

Each representative of the medical staff and hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the medical staff or hospital.

12.2-2 FOR PROVIDING INFORMATION

Each representative of the medical staff and hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the medical staff or hospital concerning such person who is, or has been, and applicant to or member of the staff or show did, or does, exercise clinical privileges or provide services at this hospital.

12.3 ACTIVITIES AND ACTION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to application for appointment, reappointment, or clinical privileges; corrective action, hearing and appellate reviews, utilization reviews, other department, or committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and National Practitioner Data Bank queries and reports, peer review organizations, and similar reports.

12.4 RELEASES

Each applicant or member shall, upon request of the medical staff or hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

12.5 INDEMNIFICATION

The hospital shall indemnify, defend and hold harmless the medical staff and its individual members from and against losses and expenses (including attorney's fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to, (1) as a member of or witness for the medical staff department, service, committee or hearing panel, (2) as a member of or witness for the governing board or any hospital task force, group, or committee, and (3) as a person providing information to any medical staff or hospital group, officer, board members or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a medical staff member or applicant. The medical staff or member may seek indemnification for such losses and expenses under this bylaws provision, statutory and case law, any available liability insurance or otherwise as the medical staff or member sees fit, and concurrently or in such sequence as the medical staff or member may choose. Payment of any losses or expenses by the medical staff or member is not a condition precedent to the hospital's indemnification obligations hereunder.

ARTICLE XIII
GENERAL PROVISIONS

13.1 RULES AND REGULATIONS

Medical Staff Rules & Regulations shall be developed as necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff Organizational activities as well as embody the level of practice that is to be required of each staff member or allied health professional or specified professional personnel in the hospital. The Rules & Regulations may be adopted, amended or repealed by majority vote of the Medical Executive/Credential Committee, and approval of the Governing Body, whose approval shall not be withheld unreasonably, or automatically within thirty (30) days if no action is taken by the governing body. If there is a conflict between the Bylaws and the rules and regulations, the Bylaws shall prevail.

13.2 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both sexes wherever either term is used.

13.3 AUTHORITY TO ACT

Any member or members who act in the name of this medical staff without proper authority shall be subject to such disciplinary action as the medical executive committee may deem appropriate and shall not be indemnified by the hospital.

13.4 DIVISION OF FEES

Any division of fees by members of the medical staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the medical staff.

13.5 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing, properly sealed, and shall be sent through United States Postal Service, first-class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the medical staff or officers or committee thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable
Name of department, division or committee
[c/o medical staff specialist, chief of staff]

_____*Hospital*
_____*Street*
_____*, Nevada*

Mailed notices to a member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the medical staff or the hospital which is updated annually.

13.6 DISCLOSURE OF INTEREST

All nominees for election or appointment to medical staff offices, department chairships, or the medical executive committee shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the medical executive committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeable result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.

13.7 MEDICAL STAFF PARTICIPATION IN HOSPITAL DELIBERATIONS

Medical Staff representatives as designated by the Chief of Staff shall participate in any hospital deliberation affecting the discharge of Medical Staff responsibilities.

13.8 MEDICAL STAFF MEMBERSHIP FILES

13.8-1 INSERTION OF ADVERSE INFORMATION

The following applies to actions relating to requests for insertion of adverse information into the medical staff member's quality improvement file:

(a) As stated previously, in Section 6.1-1, any person may provide information to the medical staff about the conduct, performance or competence of its members.

(b) When a request is made for insertion of adverse information into the medical staff member's quality improvement file, the respective department chair and chief of staff shall review such a request.

(c) After such a review as decision will be made by the respective department chair and chief of staff to:

(1) Not insert the information;

(2) Notify the member of the adverse information by a written summary and offer the opportunity to rebut this assertion before it is entered into the member's file; or

(3) Insert the information along with a notation that a request has been made to the medical executive committee for an investigation as outlined in Section 6.1-2 of these Bylaws.

(d) This decision shall be reported to the medical executive committee. The medical executive committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

13.8-2 REVIEW OF ADVERSE INFORMATION AT THE TIME OF REAPPRAISAL AND REAPPOINTMENT

The following applies to the review of adverse information in the medical staff member's quality improvement file at the time of reappraisal and reappointment.

(a) Prior to recommendation on reappointment, the quality improvement committee, as part of its reappraisal function, shall review any adverse information in the quality improvement file pertaining to a member.

(b) Following this review, the medical executive committee shall determine whether documentation in the file warrants further action.

(c) With respect to such adverse information, if it does not appear that an investigation and/or adverse action on reappointment is warranted, the department chair shall so inform the medical executive committee.

(d) However, if an investigation and/or adverse action on reappointment is warranted, the department chair shall so inform the medical executive committee.

(e) No later than sixty (60) days following final action on reappointment, the medical executive committee shall, except as provided in 13.8-2(g):

(1) Initiate a request for corrective action, based on such adverse information and on the department chair's recommendation relating thereto, or

(2) Cause the substance of such adverse information to be summarized and disclosed to the member.

(f) The member shall have the right to respond thereto in writing, and the medical executive committee may elect to remove such adverse information on the basis of such response.

(g) In the event that adverse information is not utilized as the basis for a request for corrective action, or disclosed to the member as provided herein, it may be removed from the file and discarded, unless the medical executive committee, by a majority vote, determines that such information is required for continuing evaluation of the member's:

(1) Character;

(2) Competence; or

(3) Professional performance.

13.8-3 CONFIDENTIALITY

The following applies to records of the medical staff and its committees responsible for the evaluation and improvement of patient care:

(a) The records of the medical staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital shall be maintained as confidential.

(b) Access to such records shall be limited to duly appointed officers and committees of the medical staff for the sole purpose of discharging medical staff responsibilities and subject to the requirement that confidentiality be maintained.

(c) Information which is disclosed to the governing body of the hospital or its appointed representatives -- In order that the governing body may discharge its lawful obligations and responsibilities -- shall be maintained by that body as confidential.

(d) Information contained in the quality improvement file of any member may be disclosed with the member's consent, or to any medical staff or professional licensing board, or as required by law. However, any disclosure outside of the medical staff shall require the authorization of the chief of staff and the concerned department chair and notice to the member.

(e) A medical staff member shall be granted access to the individual's own quality improvement file, subject to the following provisions:

(1) Timely notice of such shall be made by the member to the chief of staff or the chief of staff's designee.

(2) The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information -- including peer review committee findings, letters of reference, Focused Professional Performance Evaluation reports, complaints, etc. -- shall be provided to the member, in writing, by the designated officer of the medical staff, (at the time the member reviews the quality improvement file) (within a reasonable period of time, as determined by the medical staff). Such summary shall disclose the substance, but not the source, of the information summarized;

(3) The review by the member shall take place in the medical staff office, during normal working hours, with an officer or designee of the medical staff present.

(f) In the event a Notice of Charges is filed against a member, access to that member's quality improvement file shall be governed by Section 7.3-1.

13.8-4 MEMBERS OPPORTUNITY TO REQUEST CORRECTION/DELETION OF AND TO MAKE ADDITION TO INFORMATION IN FILE

(a) After review of the file as provided under Section 13.8-3(e) the member may address to the chief of staff a written request for correction or deletion of information in the quality improvement file. Such request shall include a statement of the basis for the action requested.

(b) The chief of staff shall review such a request within a reasonable time and shall recommend to the medical executive committee, after such review, whether or not to make the correction or deletion requested. The medical executive committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

(c) The member shall be notified promptly, in writing, of the decision of the medical executive committee.

(d) In any case, a member shall have the right to add to the individual's quality improvement file, upon written request to the medical executive committee, a statement responding to any information contained in the file.

13.9 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

The medical staff shall review and make recommendations to the governing body regarding quality of care issues related to exclusive arrangements for physician and/or professional services, prior to any decision being made, in the following situations:

(a) The decision to execute an exclusive contract in a previously open department or service;

(b) The decision to renew or modify an exclusive contract in a particular department or service; and

(c) The decision to terminate an exclusive contract in a particular department or service.

13.10 ADMINISTRATIVE PROCESSES

There is an Administrative process for procedures and criteria not listed in the Bylaws and will be determined yearly by the Medical Executive Committee

13.11 RADIOLOGY EQUIPMENT AND STAFF

The Medical Staff determines the qualifications of the Radiology Staff who use equipment and administer procedures. The Medical Staff approves the nuclear services Director's specifications for the qualifications, training, functions, and responsibilities of the Nuclear Medical Staff. A full-time, part-time or consulting Radiologist who is a Doctor of Medicine or Osteopathy qualified by education and experience in Radiology supervises ionizing Radiology services

ARTICLE XIV
ADOPTION AND AMENDMENT OF BYLAWS

14.1 PROCEDURE

Upon the request of (1) the medical executive committee, or the chief of staff or the bylaws committee after approval by the medical executive committee, or (2) upon timely written petition signed by at least [10%] of the members of the medical staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these bylaws.

Medical Staff Bylaws may be adopted, amended, or repealed by the following actions:

(a) Discussion of the proposed Bylaws amendment has occurred at a General Medical Staff meeting, a two-thirds (2/3) quorum of the medical staff members in person or by mailed secret ballot has been established; the ballot is provided at least twenty-one (21) days in advance by written notice, accompanied by the proposed Bylaws and/or alterations; and

(b) The approval of the governing body.

14.2 ACTION ON BYLAW CHANGE

The change shall require an affirmative vote [greater than 50%] of the members voting in person or by written ballot.

14.3 APPROVAL

Bylaw changes adopted by the medical staff shall become effective following approval by the governing board, which approval shall not be withheld unreasonably, or automatically within ninety [90] days if no action is taken by the governing board. In recognition of the ultimate legal and fiduciary responsibility of the governing body, the organized medical staff acknowledges, in the event the staff is unable to obtain an affirmative vote [greater than

50%] on amendments required for continued state licensure, approval by accrediting bodies, or to comply with court judgment, after ninety (90) day notice from the governing body may itself amend the bylaws to include terms required for state licensure, federal or state laws or regulations, approval by accrediting bodies or to comply with a court judgment. In such event, the medical staff recommendations shall be carefully considered by the governing body in its actions.

Medical staff members are provided with copies of the revisions in the bylaws, rules and regulations and medical staff policies. If approval is withheld, the reasons for doing so shall be specified by the governing board in writing, and shall be forwarded to the chief of staff, the medical executive committee and the bylaws committee.

14.4 EXCLUSIVITY

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff bylaws.

14.5 EFFECT OF THE BYLAWS

Upon adoption and approval as provided in Article XIV, in consideration of the mutual promises and agreement contained in these bylaws, the hospital and the medical staff, intending to be legally bound, agree that these bylaws shall constitute part of the contractual relationship existing between the hospital and the medical staff members, both individually and collectively. The medical staff and governing board comply with the medical staff bylaws.

14.5-1 SUCCESSOR IN INTEREST

These bylaws, and privileges of individual members of the medical staff accorded under these bylaws, will be binding upon the medical staff, and the governing board of any successor in interest in this hospital, except where hospital medical staffs are combined. In the event that the staffs are combined, the medical staffs shall work together to develop new bylaws which will govern the combined medical staffs, subject to the approval of the governing board or its successor in interest. Until such time as the new bylaws are approved, the existing bylaws of each institution will remain in effect.

14.5-1 AFFILIATIONS

Affiliations between the hospital and other hospitals, health care systems or other entities shall not, in and of themselves, affect these bylaws.

Deposition of
RABECCA JONES, R.N.

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

Case No.CV-C-17-439

December 4, 2020

CONDENSED TRANSCRIPT AND KEY WORD INDEX

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

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

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

Plaintiff,

vs.) CASE NO.: CV-C-17-439

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

Defendants.

_____)

VIDEOTAPED AND VIDEOCONFERENCED DEPOSITION OF THE 30(b)(6) WITNESS FOR PHC-ELKO, INC. d/b/a NORTHEASTERN NEVADA REGIONAL HOSPITAL, RABECCA JONES, R.N.
Taken on Friday, December 4, 2020
At 2:04 p.m. Pacific Standard Time
All Attendees Appearing Via Videoconference

Reported By: Lori M. Unruh, R.D.R., C.C.R. #389

APPEARANCES:

For the Plaintiff: SHIRLEY BLAZICH
(via videoconference) ATTORNEY AT LAW
CLAGGETT & SYKES
4101 Meadows Lane, Suite 100
Las Vegas, Nevada 89107

For PHC-Elko, Inc., et al.: TYSON J. DOBBS
ATTORNEY AT LAW
(via videoconference) HALL PRANGLE & SCHOONVELD, LLC
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Suite 350
Las Vegas, Nevada 89144

For REACH Air Medical Services, LLC, et al.: JAMES T. BURTON
ATTORNEY AT LAW
(via videoconference) KIRTON McCONKIE
50 East South Temple Street,
Suite 400
Salt Lake City, Utah 84111

For Ruby Crest Emergency Medicine: JORDAN W. MONTET
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For David Garvey, M.D.: XIAO WEN JIN
(via videoconference) ATTORNEY AT LAW
LEWIS, BRISBOIS,
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Suite 600
Las Vegas, Nevada 89118

The Videographer: Becky Ulrey,
(via videoconference) Certified Legal Videography

INDEX

EXHIBITS MARKED FOR IDENTIFICATION

MS. ULREY: This begins the 30(b)(6) video recorded deposition of Rabecca Jones taken on December 4th, 2020, at the time of 2:04 p.m.

This matter is entitled Diane Schwartz, et al., versus David Garvey, M.D., et al., Case No. CV-C-17-439, in the Fourth Judicial District Court of the State of Nevada, in and for the County of Elko.

My name is Becky Ulrey. The court reporter is Lori Unruh with Turner Reporting Services.

The attorneys participating in this Zoom proceeding acknowledge that the court reporter is not physically present in the proceeding room with the witness or counsel and that she will be reporting this procedure remotely.

If in agreement to this remote arrangement, please state your name and consent to the agreement for the record, beginning with Ms. Blaz- -- Blazich.

MS. BLAZICH: Hi. Good afternoon.

Shirley Blazich on behalf of the plaintiffs, and I consent to that arrangement.

MR. DOBBS: Tyson Dobbs for the hospital and for the deponent, and I consent.

MR. BURTON: This is James Burton. I represent REACH Air Medical. I also agree to that.

MS. MONTET: Jordan Montet on behalf of Defendant

Page 5

Ruby Crest, and I consent.
MS. JIN: Xiao Wen Jin for Defendant David Garvey, and I consent to the arrangement.
MS. ULREY: Thank you.
The reporter will now administer the oath.
* * * * *
Whereupon --
RABECCA JONES, R.N., having been first duly sworn to tell the truth, the whole truth and nothing but the truth, was examined and testified via videoconference as follows:
* * * * *
EXAMINATION
BY MS. BLAZICH:
Q Hi, Ms. Jones.
A Hi.
Q Would you mind stating -- I know you already spelled it, but I don't think that was on the record.
Would you mind for the record stating your name and spelling it for us.
A Rabecca, R-a-b-e-c-c-a, Jones, J-o-n-e-s.
Q And, Ms. Jones, have you ever had your deposition taken before?
A Yes.
Q On about how many occasions?

Page 6

A Two, I believe.
Q How long ago was the last time you gave a dep- -- gave deposition testimony?
A It's been maybe two years.
Q Are you reasonably comfortable with sort of the rules on how a deposition is to proceed, or would you like me to go over them with you?
A No. I believe I remember.
Q Okay. Fair enough.
The one thing I will say is that the oath that the court reporter just administered is the same oath that you would take if we were in a courtroom in front of a judge and a jury, and it carries with it the same obligation to tell the truth to the best of your knowledge and recollection, okay?
A I understand.
Q And I'll also let you know that if you don't know the answer to one of my questions or you don't remember something that you need to answer one of my questions, please let me know that you don't know or that you don't remember. We don't want you guessing or speculating at any point in time during the deposition, okay?
A Okay.
Q All right. Ms. Jones, are you currently employed?

Page 7

A I am.
Q Who is your employer?
A Northeastern Nevada Regional Hospital.
Q What is your job position with Northeastern Nevada Regional Hospital?
A I am the director of cardiopulmonary services.
Q How long have you been the director of cardiopulmonary services?
A This position, four years.
Q How long have you been an employee of Northeastern Nevada Regional Hospital?
A 24 years.
Q Prior to becoming the director of cardiopulmonary services, what position did you hold then?
A I was the director of informatics and education.
Q Are you a healthcare provider?
A I -- not in my current role, I don't provide direct care, but I can at times step in to provide direct care to patients.
Q All right. So your role as the director of cardiopulmonary services does not require you to provide direct patient care; is that true?
A Not normally, but I do step in if I need to to staff my areas.
Q Okay. Are you a physician? A nurse? A respiratory therapist?

Page 8

A I'm an R.N.
Q All right. Where did you do your R.N. training?
A Great Basin College here in Elko, Nevada.
Q And did you graduate from Great Basin College?
A I did.
Q What year was that?
A With my R.N. degree was in 2003. My master's degree was in 2012 from Walden University.
Q Where is Walden University?
A Minnesota.
Q Was that like a remote degree or an online degree?
A Yeah, online, with some -- yeah, online.
Q Okay. What is your master's in?
A Nursing leadership and management.
Q All right. Other than in the state of Nevada, have you ever held a nursing license in any other state?
A No.
Q Have you ever had your nursing license revoked or suspended for any reason in the state of Nevada?
A No.
Q And is it your understanding today, Ms. Jones, that you have been designated as a corporate representative to testify on behalf of Northeastern Nevada

Page 9

Regional Hospital?
A Yes.
Q And you've agreed to testify on behalf of Northeastern Nevada Regional Hospital?
A Yes.
Q And do you understand that your testimony today will be binding upon Northeastern Nevada Regional Hospital?
A Yes.
Q Okay. In preparation for your deposition today, what documents did you review?
A I reviewed a code blue policy, an occurrence report, crash cart logs, an audit log. I was able to review some of the didactic portions of -- was it called testimony? I don't know if that's the right term.
Q Is it deposition transcripts?
A Deposition transcripts, portions of it related to equipment.
That's all I can think of off the top of my head.
Q All right.
MR. DOBBS: She also reviewed billing records.
THE WITNESS: Oh.
MR. DOBBS: I'll just help her out just so we get a com- -- exhaustive list, cause this one clearly is -- is more extensive than the others.

Page 10

MS. BLAZICH: Right.
MR. DOBBS: The current occurrence report policy.
THE WITNESS: (Nodding head.)
MR. DOBBS: Some of the medical records as far as the consents.
THE WITNESS: Yes, the consents.
Q (BY MS. BLAZICH) In the medical records, correct?
A In the medical record, yes.
Q All right. Well, if we need to add anything to the list, we can as we kind of go through everything.
All right. Let me see.
Oh, did you review the list of on-call medical providers?
A I did review that.
Q All right. I'm going to jump around a little bit to kind of get the easy fast ones out of the way first, if you don't mind.
A Sure.
Q So I'm going to I think start with topic 24 of the list of the on-call medical providers.
MR. DOBBS: Shirley?
MS. BLAZICH: Yes.
MR. DOBBS: Sorry -- sorry to interrupt.
Did you go through the topics that she's

Page 11

designated for?
MS. BLAZICH: I did not. I'm happy to do that.
So it's -- based on my understanding in conferences with Mr. Dobbs, Ms. Jones is going to be testifying as to topics 11, 24, 25, 26, 27, 28, 29, 35, 37, and 39.
MR. DOBBS: All right. Sorry about that.
No. That's --
MS. BLAZICH: No, not at all.
MR. DOBBS: And then the one caveat, Shirley, is that we've got the motion pending as to the portion of topic 11 that deals with sentinel event reporting. She -- she'll be talking about the occurrence reporting.
MS. BLAZICH: Right. I understand.
MR. DOBBS: Thank you, Shirley --
MS. BLAZICH: Sure, no problem.
THE REPORTER: I didn't hear that. I didn't hear whatever that was.
MR. DOBBS: I just told her -- I just told her thank you.
Q (BY MS. BLAZICH) All right. Let me pull up the first exhibit.
All right. Ms. Jones, can you see the document that I've put up on the screen, the NNRH emergency department unassigned call schedule for June of 2016?

Page 12

A Yes, I can.
Q And is this the document that you reviewed in preparation for your deposition today?
A Yes, I did.
Q Is it your understanding that this document represents the list of physicians who were on call in the emergency department at Northeastern Nevada Regional Hospital in June of 2016?
A Yes.
Q All right. So explain to me -- because there's -- I see the column on the left where it says the dates, and it runs 1 through 30, which are the number of days that there is in June.
But what I'm not able to tell is what are -- if a physician is on call, are they on call for the entire 24-hour period, or are they on call for a 12-hour period? Are you able to explain that?
A So they're on call for a 24-hour period.
Q All right. So where it says June 1st, pediatrics, we have Dr. Slothower, he would have been on call for the entire 24-hour period of June 1st.
A Well, if you look down at the bottom -- if you could show me down towards the bottom, the primary care providers, those certain ones of those cover their own patients from 7:00 to 5:00 during the day, and then the

Page 13

on-call hospitalist would cover from 5:00 to 7:00 a.m.
So some of those providers, primary care doctors, would cover their own during those day week hours. Otherwise, they would call the scheduled on-call person.
Q All right. So is the scheduled on-call person always a hospitalist?
A Only for the hospitalist column.
So, for example, like you said, Dr. Slothower --
Q Yeah.
A -- they're primary care providers, so he wouldn't cover Dr. Janhunen's patient Monday through Friday during the day. They'd call Dr. Janhunen to see what she would want to do.
But after those hours, they'd call Dr. Slothower.
Q So let me make sure I -- I understand this.
If -- if Dr. Slothower -- Slothower is covering their own patient from 7:00 a.m. to 7:00 p.m., then does that mean after -- sorry -- 7:00 a.m. to 5:00 p.m. Monday through Friday, does that mean that after 5:00 p.m. a different physician is responsible for being on call?
A Yes. They would call this on-call person. And so irregardless of who they normally see, this is who they would get contacted to help consult or cover cares.
Q All right. So this list of the call schedule, are these the people that you would call after 5:00 p.m.

Page 14

Monday through Friday?
A Yes.
Q Okay. As opposed to the people who are working 7:00 a.m. to 5:00 p.m. Monday through Friday.
A Yeah.
And not all of them are primary care on the list though. So like anesthesia, for example, there's no primary care doctor who works all on Monday through Friday during the week. They're always calling anesthesia on this list.
Q So anesthesia is always on call?
A Yes.
Q So it's -- there's nobody in the hospital who is routinely just there to provide anesthesia services. You have to call for anesthesia services when you need them; is that right?
A No, no.
Q Okay.
A They are in-house, but they always call this person that's on the call schedule regardless -- irregardless of who's here or scheduled. There's no -- like that primary care deal doesn't apply to certain doctors on that list.
Q Okay. So if there is anesthesiologists or CRNA who is working during the day at the hospital and somebody

Page 15

needs anesthesia services, would they call the person who's working, or would they call the person on the call schedule?
A They would call the person on the call schedule.
Q Got it.
Is -- is anesthesia a service that is available 24/7 at Northeastern Nevada Regional Hospital?
A In-house?
Q Either in-house or through an -- an on-call provider.
A It's available through an on-call provider 24/7.
Q When is it available -- well, sorry. Strike that.
And that was true in June of 2016, correct?
A Correct.
Q Are there times where there is someone from anesthesia working at the hospital as part --
A Yes.
Q -- of a regularly scheduled shift?
A Yes.
Q Okay. What is that regularly -- well, what was that regularly scheduled shift in June of 2016?
A It would be Monday through Friday during scheduled surgery hours.
Q Okay. So that person who was working would be

Page 16

responsible for any of the scheduled surg- -- surgery procedures happening at the hospital.
A Correct.
Q Okay. And so that's why you don't want to pull them away from that if you need to call in anesthesia. That's why you go to the on-call list.
A Correct.
Q Got it.
All right. So according to this document -- which for the record let's mark the on-call schedule as Exhibit 1.
(Plaintiff's Exhibit 1 was marked for identification by the reporter.)
Q (BY MS. BLAZICH) On June the 22nd, which is a Wednesday -- let's see here.
Let's see June 22nd. Sorry. It's kind of hard to draw this, but...
All right. June 22nd is a Wednesday, and we have general surgery, we have Dr. Ward on call?
A Correct.
Q I take it Dr. Ward is a general surgeon.
A He is a general surgeon.
Q Okay. For cardiology, we have Dr. Burlew on call?
A Correct.

Page 17

Q And are these folks on call until midnight, and then at midnight a new person is on call?
A Till 7:00 a.m.
Q Till 7:00 a.m. the next day.
A Yes.
Q Okay. So somebody who was on call the evening of June 22nd would be on call until 7:00 a.m. the morning of June 23rd.
A Correct.
Q Got it.
All right. For anesthesia, it says Wing.
Is Wing -- is that a physician or a CRNA?
A CRNA. All of ours are CRNAs.
Q Got it.
What is CRNA Wing's first name?
A Ron.
Q And then the hospitalist is Hendrickson.
A Correct.
Q All right. I see blanks, so it appears that there was nobody available -- or there was no one on call for orthopedic surgery, interventional cardiology, podiatry, urology, or ENT --
A Correct.
Q -- on June 22nd.
A That is correct.

Page 18

MS. BLAZICH: All right. Let's see. For Exhibit 2, I'm going to pull up the full hospital medical dir- -- medical record. Give me just a second.
All right. All right. Let's mark this as Exhibit 2. It's the Northeastern Nevada Regional Hospital medical record produced and Bate stamped NEN1 through NEN -- I think 83, if I'm not mistaken.
(Plaintiff's Exhibit 2 was marked for identification by the reporter.)
Q (BY MS. BLAZICH) Ms. Jones, did you review this complete 83-page document in preparation for your deposition today?
A I don't believe all 83 pages.
Q You just reviewed certain portions of it?
A I believe so.
Q Okay. Let's see here.
Give me a second just to get to the code sheet.
All right. Ms. Jones, do you have a paper version of this available to you to refer to during the deposition? This is the cardiac arrest record for the hospital. It's -- it's Bate stamped NEN33.
MR. DOBBS: Yes. I -- I can provide that to her.
MS. BLAZICH: Just cause I don't know how to flip the page, Tyson, and I don't want to make her read sideways.

Page 19

THE WITNESS: Thank you.
I have it.
Q (BY MS. BLAZICH) Okay. All right. Great.
All right. So where -- this cardiac arrest record that is Bate stamped NEN000033, is this one of the documents that you reviewed in preparation for your deposition today?
A Yes.
Q All right. And so my understanding that this is the -- that this is the code sheet for Douglas Schwartz from the early morning hours of June 23rd, 2016, correct?
A Correct.
Q All right. All right. So I want to go through some of the -- some of the writing on this -- this document just to confirm some information, all right?
Well, do I need to keep the exhibit up? I don't need to. You have it in front of you, right?
A Yes.
Q Okay. All right. On the code sheet, where it lists out the team members, team members would be indicative of the people participating in the code, correct?
A That's correct.
Q All right. And we have listed at number one, Dr. David Garvey, correct?

Page 20

A Yes.
Q He was the attending physician.
A Yes.
Q And then we have several nurses listed.
On number six, we have -- it says Ronnie R.N., REACH Air; do you see that?
A Yes.
Q Is it your understanding that this is Ronnie Lyons who was a flight nurse for REACH Air who was participating as a team member for this cardiac arrest?
A Yes.
Q Okay. And what's the best way to refer to this? Is this the code sheet? The cardiac arrest record?
A We call it our code sheet.
Q Code sheet. All right. The industry people call it the code sheet. Okay. Thank you. That's what I'll call it too then.
And for item number seven, we have Barry R.N., REACH; you see where it says that?
A Yes.
Q And is it your understanding that that's referring to Barry Bartlett, the -- it says R.N., but who's a flight paramedic with REACH Air?
A Yes.
Q Okay. And he's identified as being part of the

Page 21

team on this code sheet, correct?
A Correct.
Q All right. There is a section on the right-hand side underneath all the names that talks about IVs being present and IVs being started --
A Yes.
Q -- do you see that?
It says IV present, 20g right R hand; do you see that?
A Yes.
Q And then it says IV started, 20g R wrist, right wrist; do you see that?
A Yes.
Q Are you able to tell from this record who placed the IV in the right hand?
A Not from this document unless I can see it farther down.
Q So a couple -- just a couple lines down it talks about needle size, solution, and then it says by whom. And it says EMS, and then in parentheses the number 1. And then there's a slash, and it says paramedic student Kristina.
Do you see that?
A Yes.
Q Just trying to understand what that means.

Page 22

Does that mean that EMS or a paramedic placed the IV -- both IVs in the right hand and the right wrist?
A No.
The -- the one that says IV present means it was already present before this code. So that should have been documented in their medical record when that one was started and by who started that one.
The IV started during the code, the "by whom" would be saying who started the IV started during the code one.
Q Got it.
And so would that then indicate that EMS or the paramedic was the one who started the IV?
A Yes.
Q Do you know in this case was it Paramedic Barry Bartlett that started the IV?
A I do not know.
Q Do you know if it was Flight Nurse Ronnie Lyons who started the -- the IV?
A No, I do not know that.
Q All right. Based on the fact that it says EMS 1 in parentheses slash paramedic, does that lead you to believe that it was not one of the Northeastern Nevada Regional Hospital nurses or staff who started the IV in the right wrist?

Page 23

A Based on this documentation, I would say that is correct.
Q Okay. It was one of these other providers, EMS or the paramedic, who likely started the IV in the right wrist.
A That is correct.
Q All right. Going to sort of the first line -- handwritten line of treatment information, it says at 0018, so just after midnight, 12:18 a.m., ketamine 180 milligrams IVP, rocuronium by REACH Air Nurse Ronnie R.N.; do you see that?
A Yes.
Q Is it your understanding that that means that both ketamine and rocuronium were administered by Ronnie Lyons?
A Yes.
Q Do you know if the ketamine came from the hospital pharmacy supply or if it came from the REACH medication supply?
A I could not say that. I wasn't there. And by this document, that doesn't tell me where it came from.
Q Okay. Same question for the rocuronium, are you able to tell whether that came from the hospital or came from REACH?
A Not from this document.

Page 24

Q All right. At 0020, so 12:20 a.m., it indicates that there's an ET tube attempted, right? So that means an endotracheal intubation attempt is made, correct?
A Correct.
Q It indicates that it's unsuccessful, correct?
A Correct.
Q And that the -- they started bagging the patient.
A Correct.
Q It also indicates that a 7.5 tube was used, correct?
A Correct.
Q Is it typical in one of these code sheets to document the specific tubes or equipment being used during a code?
A Ideally we would like them to document the size of a tube. I won't say that that is always done that way.
Q What would -- why ideally would the size of the tube be documented?
A Sometimes it's hard to find out what size that tube is after, and we do document ongoing assessments of that tube and its placement; and so knowing the tube size to start helps us.
Q All right. Do you know in this case whose tube was used, whether it was the hospital's or REACH Air's tube?

Page 25

A By this document, I wouldn't know. I -- I would assume all of this is from the hospital, but that's an assumption.
Q Okay. What would be the basis for that assumption?
A Because that's our typical practice. We --
Q Is for --
(Reporter interrupted; multiple speakers.)
THE WITNESS: We use our medications and our supplies from our crash cart for these kinds of things.
Q (BY MS. BLAZICH) Okay. So is that the policy of the hospital, that its equipment is used for all procedures that are attempted on hospital grounds?
A No. There's no policy saying that.
Q It's just sort of the custom and practice of the hospital to do it that way?
A Yeah.
Q And that includes if an outside provider comes in to perform or assist with a procedure?
A Can you restate the question?
Q Sure.
Would that still apply, using hospital supplies, if an outside provider comes in to assist with the procedure?
MR. DOBBS: Incomplete hypothetical.

Page 26

THE WITNESS: I would say --
MR. BURTON: Join. Sorry. Join that objection.
I was trying to get off mute. Sorry for interrupting.
THE WITNESS: I would say we most often use our supplies, but there are circumstances I have been in personally, not this one, where we've used flight team supplies when we're transferring a patient and taking a patient somewhere else.
Q (BY MS. BLAZICH) So generally hospital supplies are used, but there have been occasions where the outside providers' supplies would be used as well.
A Yes.
Q All right. And if outside providers' supplies are used, would it -- would the custom and practice of the hospital be to still document the equipment that's being used in this code sheet?
A I would say if the -- I -- I couldn't answer that. I -- I don't know of how many situations we've had where there's a code and other supplies used, so I don't know of a past practice of what would be customary for that.
Q All right. At 0035, 12:35 a.m. -- no, I'm sorry. I skipped ahead.
At 12:33 a.m., there's another unsuccessful

Page 27

intubation attempt, correct?
A Correct.
Q Also indicates that a 7.5 tube is used, correct?
A Correct.
Q And then there's a slash, and it indicates that a 9 -- I don't know if these are millimeters, it just has the number 9 -- tube is used, correct?
A Correct.
Q And these intubation attempts are, according to this record, made by Barry Bartlett, correct?
A Correct.
Q This attempt used two different size tubes.
A That's what the documentation would make it appear, right.
Q And according to the documentation, both were unsuccessful, correct?
A Correct.
Q All right. At 12:35 a.m., CPR is noted to be in progress, correct?
A Correct.
Q Ms. Jones, as a registered nurse, have you had opportunities to participate in codes where a patient is attempting to be intubated?
A Yes.
Q Okay. So CPR is -- is commenced when the patient

Page 28

is bradycardic or their oxygen saturation is below a certain level, correct?
A No, not necessarily.
Q When -- if you can tell me, when would you start CPR as opposed to using a BVM to simply reoxygenate a patient?
A I would not be the person that makes that decision. That would be a doctor.
Q Okay. So a doctor would say we're going to do CPR now, and then the staff would respond to that.
A Correct.
Q Got it.
All right. On that line at the end it says brady. That means bradycardic, correct?
A Correct. It --
(Reporter interrupted; multiple speakers.)
THE WITNESS: On the same line it said HR 36, so that's heart rate 36, which is a bradycardic rate.
Q (BY MS. BLAZICH) All right. On oxygen saturation it says 37 percent, correct?
A Correct.
Q And for the record, what does bradycardic mean?
A A slower than normal heart rate.
Q All right. Okay. At 12:36 a.m., it says King airway placed, correct?

Page 29

A Correct.
Q Do you know whether that King airway came from hospital equipment or from REACH's equipment?
A I -- I don't have personal knowledge of where it came from.
Q And according to this record, the King airway was placed by Barry Bartlett, correct?
A Yes.
Q All right. Skipping one line, going down to 12:44 a.m., it notes another endotracheal tube attempt -- attempted by Dr. Garvey, correct?
A Correct.
Q And that was also unsuccessful.
A Correct.
Q There's no documentation of what tube size was used there. Is there --
A Correct.
Q Is there a reason for that, why -- why you wouldn't document it when the physician is making the intubation attempt?
A I can't say for this specific event.
But I will say, like I stated earlier, it's a nicety to have, so if someone says we've intubated with a 7 and a half, we document it. If that's not said, it's not something we -- we work on getting during this

Page 30

situation.
Q At 12:47 a.m., there is another endotracheal intubation attempt by Dr. Garvey, which is unsuccessful, correct?
A That's correct.
Q All right. At 12:50 a.m., it's noted that oxygen -- O2 sats are 65 percent, CPR continues, asystole; do you see that?
A Yes.
Q Did I pronounce that correctly?
A Asystole.
Q Asystole. See, I knew I didn't.
Okay. Asystole. Really? Or are you putting me on? Is that how it's pronounced?
A No. That's really it.
Q That's really it? Okay.
What does that mean, asystole, for the record?
A It means no electrical conduction on the heart monitor.
Q So is that kind of like in laymen's terms a flatline on the heart monitor?
A Yes.
Q All right. So after there's a flatline of the patient at 12:50 a.m., at 12:52 a.m. it indicates that there's another attempt to place an endotracheal tube --

Page 31

sorry -- to perform an endotracheal intubation by Barry Bartlett from REACH, correct?
A Correct.
Q And that's also an unsuccessful attempt.
A Correct.
Q At 10:53 a.m., there is another unsuccessful attempt to intubate the patient, correct?
MR. DOBBS: Form.
You said 10:53. I think you mean 12:53.
MS. BLAZICH: Oh, I'm sorry. Yeah.
Q At 12:53 a.m., it's documented that there's another unsuccessful attempt at endotracheal intubation, correct?
A Correct.
Q It doesn't indicate who attempted that particular intubation attempt.
A It's hard to tell. There's a sticker, and so --
Q There is?
A There's a sticker -- a patient sticker name over on the right-hand bottom side. That's where we place the sticker.
Q I see it.
A And it does look like there's some writing that had started underneath there.
Q Okay. So we don't know what it says under the

Page 32

sticker.
A No.
Q But other than that, we're not able to tell who performed that intubation attempt, correct?
A Correct.
Q All right. Skipping to 12:57 a.m., it says NPA placed by Dr. Garvey; do you see that?
A Yes.
Q What is an NPA?
A A nasopharyngeal airway.
Q Do you know if that device came from hospital equipment or REACH equipment?
A Based on this documentation, I wouldn't know. I -- assumption again.
Q All right. At 12:58 a.m., again it's noted that the patient is asystole.
A Correct.
Q Okay.
A And you pronounced it beautifully.
MS. BLAZICH: I'm sure afterwards Tyson's going to call me to say ha-ha, it was asystole the whole time.
All right.
MR. DOBBS: Wait till -- wait till you start talking about a Bogie or a Bozie or a Bougie.
MS. BLAZICH: Bougie or a yar- -- yarmulke and

Page 33

all that stuff, yeah.
Q Okay. And, again, asystole means pulseless electrical activity, correct -- oh, no.
A No. Asystole means --
Q What did you say it meant?
A -- no electrical activity on the cardiac monitor.
Q All right.
A Pulse is a different thing.
Q Do we know if -- if that condition, asystole, if that -- if the patient was in that status from 12:50 a.m. to 12:57 a.m., like he didn't regain a pulse during that time, did he, based on -- based on the code sheet?
A Based on the code sheet, no.
Q Okay. So he was in asystole the entire time, those -- those seven minutes.
A I would have to, based on the documentation, lean that that is what occurred, yes.
Q Okay. So even though it indicates -- sorry.
At -- at 12:58 a.m., that 02 saturation is 67 percent, the patient is still in asystole, correct?
A Yeah. 02 sat at 69 percent and still doing CPR in asystole.
Q Okay. Patient has not regained a heartbeat; is that what that means?
A I have to assume -- I have to assume there's no

Page 34

pulse.
Asystole is electrical activity.
Q But that there's no pulse, meaning there's no heart rate --
(Reporter interrupted; multiple speakers.)
MS. BLAZICH: All right. So hold on. Let me ask the question again.
Q So at 12:58 a.m., the patient's in asystole, which -- does that mean there's no heartbeat?
A It means there's no electrical activity on the cardiac monitor.
Q Okay. So there could potentially still be a heartbeat.
A Yeah. Your -- your ventricle of your heart could still be pumping, but you're not getting the electrical activity on a monitor.
Q At -- skipping ahead a couple of lines, at 1:08 a.m., it appears to say cric attempted by Dr. Garvey; is that correct?
A Yes.
Q It doesn't say successful or unsuccessful.
Can we interpret anything from the way that the document is written as to whether this cric was attempted and completed or attempted and not completed?
A No. Just that it was attempted.

Page 35

Q Okay. At 1:13 a.m., it appears that the patient is still in asystole and the team is continuing CPR.
A Correct.
Q If you can look -- so the next page, which is NEN35 -- sorry -- no, no. There's a 34, which I'm going to skip over.
But if you go to NEN35, that appears to be the rest of the sort of handwritten log of the code.
A Yes.
Q And -- and I don't want to spend a bunch of time going through all the time stamps, but I want to ask you, other than that cric attempt that we saw at 1:08 a.m., do you see documented any other attempts to perform a cric during this code?
A No, there are no other documented attempts.
Q Are there any other documented attempts to perform any other type of surgical airway?
A No, nothing documented of any attempts.
Q After -- after 1:13 a.m. -- no. Sorry. Strike that.
After the cric was attempted at 1:08 a.m., are there any other attempts at intubation that are made as far as you can tell from this document?
A Nothing documented.
Q All right. Going back to the rocuronium and the

Page 36

ketamine that were administered to Mr. Schwartz as part of this code, if these medications came from a hospital inventory, would you expect to see them on the medication administration record?
A Not necessarily. This would be an administration record, this code sheet.
Q Okay. So medications that are listed on the code sheet would not necessarily be part of the MAR, the medication administration record?
A That's correct. We wouldn't go double document it in another location.
Q All right. What about an order for those medications to be given, would you agree with me generally -- oh, do -- do you need a break or...
MR. DOBBS: There is -- there is something overhead, if we could --
THE WITNESS: I do need a break. They just called a STEMI alert. That's my department, if I can just make sure --
MR. DOBBS: Yes.
THE WITNESS: -- that I have --
MS. BLAZICH: Let's go off the record.
MS. ULREY: We are off the record at 2:54 p.m.
(Recess.)
MS. ULREY: We are back on the video record at

Page 37

2:57 p.m.
Q (BY MS. BLAZICH) All right. Ms. Jones, let me just remind you that you're still under oath.
A Okay. Thank you.
Q Okay. Would you expect to see a written physician order for the administration of ketamine or rocuronium in the case of a planned endotracheal intubation?
A Not necessarily, cause it's done timely. It's done, here's your order, give it. They do it within a certain time frame.
But this it looks like was during a code situation that it was administered, right? That's my assumption.
Q Well -- so is it your understanding that -- that the patient was already in a code when the -- when ketamine and rocuronium were first administered? Or can you not tell from this document?
A I guess I couldn't tell from this document.
I would assume they're charting it on the code sheet, so we are in a code state at this point.
Q All right. But -- but you can't tell from the document -- there's no documentation here in the code sheet about what the patient's vital signs were prior to administering ketamine or rocuronium.

Page 38

A Not on this document.
Q Okay. Would you expect to see a written physician order to perform an endotracheal intubation on a patient?
A No.
Q A verbal order would be enough?
A An -- a verbal order -- normally they wouldn't put an order in at all because they're performing it, so they're not giving anybody an order necessarily.
Q If a physician is intending to perform an endotracheal intubation, but he or she is delegating the intubation part to another provider, would you expect to see an order written? So in other words, the attending physician's not performing the intubation himself.
A No. It would be a verbal.
Q It would be a verbal order, but you would still expect a verbal order to be given?
A For someone to begin an intubation?
Q Well, to direct another provider to perform an intubation.
A Yes, that would be directed by a provider.
Q Right.
So I wouldn't expect the attending physician to give himself an order to perform an intubation --
A Right.

Page 39

Q -- right?
But if he was directing another person to perform an intubation who was not a physician, there would need to be a verbal order to do so, correct?
A Yes.
MS. BLAZICH: Okay. We're going to come back to the medical record, but I want to go to the billing record next.
And let's mark -- the billing record will be Exhibit 3. Let me just find it.
(Plaintiff's Exhibit 3 was marked for identification by the reporter.)
Q (BY MS. BLAZICH) Okay. So this is -- Ms. Jones, this is Exhibit 3, which appears to be the billing records for Northeastern Nevada Regional Hospital for the care and treatment that was provided to Douglas Schwartz on June 22nd and 23rd of 2016.
Have you seen this document before?
A Yes.
Q Is this one of the documents that you reviewed in preparation for your deposition today?
A Yes.
Q All right. So at the bottom of this document, line -- I can't tell if it's line 50 or line 150, but it's emergency room, there is a charge for an endotracheal

Page 40

intubation; do you see that?
A Yes.
Q $981, correct?
A Yes.
Q Are you able to tell from the code sheet that we just went over whether or not the endotracheal intubation was ever successfully performed?
A No.
Q Well, it appears from the code sheet, wouldn't you agree, that the endotracheal intubation was never successfully performed, correct?
A Correct.
Q All right. And going to the next page, at the top we see charges -- well, we see duplicate charges and then a reversal of one of the charges for a cricothyroid- -- thyrotomy.
Cricothyrotomy or cricothyroidotomy? I'm just going to say cric. You know what I'm talking about, right?
A Yes. That's why we call it cric.
Q Yeah. It's a tongue-twister.
All right. So there's a charge for $2,092 for a cric procedure, correct?
A Correct.
Q Based on the code sheet that we went over, are

Page 41

you able to tell whether a cric was ever successfully performed?
A No.
Q In fact, it would indicate, since the patient was in CPR and passed away, that the -- any attempts at a cric were unsuccessful, correct?
A Correct.
Q All right. There is a charge for $1,631 for CPR that was performed, correct?
A Correct.
Q There is a charge for $3,160 for critical care that was performed.
A Correct.
Q Do you know as you sit here today what scope of services are included in that code for critical care?
A I can't tell you exactly. I can tell you a general concept.
Q Sure. Go ahead.
A So there are level charges in the ER, level one, two, three, four, five, six, and critical care. And those level charges are based on points they get for certain services and levels of care that they provide, and that point system then calculates what level that -- of care they received.
Q Okay. All right. Below that it says IV push

Page 42

initial drug $261; do you see that?
A Yes.
Q Any idea what that initial drug was? What drug is that referring to?
A I would have to look at the chart to see what first IV push drug the patient received.
Q Okay. Cause there's some drugs listed below that where it says drugs requiring DET code.
A Yeah. So the -- the --
Q Do you see that?
A Yeah. The -- those drugs are the actual charge for the drug, the -- the cost of the drug.
That IV push above is the charge for the actual nursing staff pushing and monitoring of that patient while we gave that drug.
Q Understood.
So it's -- the IV push is for the nursing care, not for the actual cost of the drug.
A That's correct.
Q Okay. So below that we have several drugs. I'm going to mispronounce all of them.
Ondansetron? Ondansetron?
A We call that Zofran.
Q Zofran. Okay.
$55.12, correct?

Page 43

A Yes.
Q Hydromor- -- morphine or morphone?
A Uh-huh.
Q Hydromorphone?
A That's correct.
Q $36.50.
And then Zofran again for $55.12, correct?
A Correct.
Q All right. Below that we have a charge for ketamine, 100 milligrams, $36.50, correct?
A Correct.
Q Do you see that?
A Yes.
Q Would that indicate to you that that drug came from hospital -- from the hospital?
A Yes.
Q So it's the hospital's drug that's being used, that's why the hospital's charging for it, correct?
A Correct.
Q I don't see a charge for rocuronium.
A That's correct.
Q There is no charge for rocuronium, correct?
A That's correct.
Q Would that indicate to you that the rocuronium that was used during Mr. Schwartz's code likely came from

Page 44

REACH?
A No, I would not make that assumption.
Rocuronium -- these drugs are kept in an AcuDose, so when they pull it from an AcuDose, the charge is automatically generated from pulling it from that dispensing machine.
The rocuronium is kept in an RSI kit at bedside, so there's no manual charging of that drug. Someone would have had to remember to make sure to let pharmacy know to bill out that drug.
This is a common missed thing when we go to code meds, to miss some of those charges.
Q Okay. So the rocuronium would come from a rapid sequence induction kit.
A Correct.
Q It wouldn't come from -- I don't know what you guys use at your hospital. Something like a Pyxis or --
A Yeah. It's called AcuDose, but a medication-dispensing system, yes.
Q All right. So can you tell one way or the other, based on the bills that you've reviewed and the code sheet, whether or not the ketamine came from the hospital or came from REACH?
A The ketamine would have come from the hospital. We -- we billed it out.

Page 45

Q Sorry. I see that.
The rocuronium.
A The rocuronium, I could not say for sure where it came from.
Q Is the RSI kit something that you would expect to see a line item charge for, or would that be included in the endotracheal intubation charge?
A No. We would still have the line item of the drug -- the -- the specific drug charge.
Q Oh, okay.
Is there a charge for the RSI kit being used?
A No, no. Just the drug.
Q Just the drug. All right.
All right. Let's go back to Exhibit 2, which is the full medical record.
Just a second. I'm just going to go right to the document.
All right. We're -- I'm going to go to NEN30, 30, 31, and 32.
This thing makes me go through it one-by-one.
All right. All right. This is a document entitled consent for services and financial responsibility.
Ms. Jones, did you review this document in preparation for your deposition today?

Page 46

A Yes.
Q And it's a three-page document, correct?
A Correct.
Q Okay. And just for -- quick question about this.
The document is signed by Diane Schwartz, who's the wife of Douglas Schwartz, correct?
A Correct.
Q There's no similar document that's signed by Douglas Schwartz?
A Not that I see.
Q Okay. All right. I am going to go to the documents within the medical records Bate stamped NEN22, 23, 24, and 25.
Ms. Jones, are these -- these pages, 22 through 25, is that something that you reviewed in preparation for your deposition today?
A Yes.
Q All right. What -- if you know, what does it mean, kind of in the middle of the document, where -- where it says departure?
MR. DOBBS: Which page is that? Sorry.
MS. BLAZICH: 22.
MR. DOBBS: Okay.
THE WITNESS: That is where the -- it looks like the nurse had signed out from that patient's care

Page 47

basically.
Q (BY MS. BLAZICH) Okay. Does it mean just -- just that one nurse, in this case Donna Kevitt, has signed out, or does it mean that the chart has been closed and locked?
A Just hers, her sign-out.
Q Okay. What -- what does it mean when it says outbound message sent?
A So our ER system is called MEDHOST EDIS. Our inpatient legal medical record is MEDHOST, and EDIS sends messages back and forth to our main system.
Q From the ER system to the main system?
A Yes.
Q Okay. And does somebody need to generate these outbound messages being sent, or does the system automatically do it?
A It depends on what type.
Q Okay. Can you explain that?
A So, for example, it -- the nurse might complete something or sign a document; and once they do the signing of it, it will then prompt the system to send it. Nobody has to tell it to send, but it's an action that they do that makes it send.
Q Got it.
A Does that make sense?

Page 48

Q I think so.
A Okay.
Q All right. So here we have at -- on June 23rd, 2016, at 9:24 a.m., people start coming in and viewing the results here.
So I'm kind of -- I'm starting right here where it has Dr. Stefanko -- Robert Stefanko's name; do you see that?
A Yes.
Q Do you personally know Dr. Robert Stefanko?
A Yes. Dr. Stefanko.
Q Stefanko. Thank you.
How do you know Dr. Stefanko?
A Just through work.
Q Is he a physician who works in the emergency department from time to time?
A Yes.
Q Okay. Based on what you've reviewed in preparation for your deposition today, do you know if Dr. Stefanko was a provider for Doug Schwartz?
A Not to my personal knowledge, no.
Q Okay. You don't know whether or not Dr. Stefanko provided any direct patient care to Doug Schwartz.
A I do not know that, no.
Q Okay. If Dr. Stefanko did not provide direct

Page 49

patient care to Doug Schwartz, do you know how or why he would be accessing Mr. Schwartz's medical record at 9:24 a.m.?

A I don't have firsthand knowledge of why he would access it.

Q Does this document indicate that Dr. Stefanko accessed Doug Schwartz's medical record at 9:24 a.m. on June 23rd, 2016?

A Yes.

Q And so if we list -- if we go through sort of the list of some of the items, it appears that Dr. Stefanko reviewed -- Dr. Stefanko reviewed the CBC with auto diff, correct?

A Correct.

Q He reviewed something called a CMP.

What -- what is that?

A A comprehensive metabolic panel.

Q Got it.

So Dr. Stefanko reviewed that.

A Correct.

Q He reviewed -- lipase, is -- am I pronouncing that correctly?

A Lipase.

Q Lipase. He reviewed those results.

A Correct.

Page 50

Q Basically he reviewed everything up through CT abdomen/pelvis IV only.

A Correct.

Q Okay. As you sit here today, do you have any explanation for why Dr. Stefanko viewed Mr. Schwartz's chart?

A I have possible conjecture, but I do not have any personal knowledge of why he'd access it.

Q Okay. Based on your experience working at Northeastern Nevada Regional Hospital for 24 years, what are your thoughts as to why a different provider might view a patient's chart after the fact who -- who was not providing direct care to that patient?

A If that provider has asked for a consultation, if there's a peer review that occurs, are the couple of reasons that I would think of that somebody else would -- another provider would review a chart.

Q Would you yourself consider it a HIPAA violation for somebody who did not provide patient care to review a patient's chart?

MR. DOBBS: I'm going to object, it calls for an expert medical opinion and -- or an expert opinion, and it's outside the scope of her designation, and I'm going to instruct her not to answer. I don't -- I don't think that's part of why she's been called here to testify to.

Page 51

She's called to testify as to facts, not offer opinions about the legal conclusions about the reasoning for anybody looking at the chart.

She already said she doesn't know why Dr. Stefanko accessed the chart, so --

MS. BLAZICH: Well, as it --

MR. DOBBS: -- I think that's an inappropriate question.

Q (BY MS. BLAZICH) Well, and I'm -- for the record, I'm not asking you for -- from a legal perspective, Ms. Jones. I'm asking you as a registered nurse who has been working at the hospital for 24 -- 24 years, from a -- from the perspective of a provider of healthcare, would it be a HIPAA violation, based on your understanding of HIPAA, to look at another -- a patient's records who's not your patient?

MR. DOBBS: I'm going to instruct her not to answer the question. It has nothing to do with the -- the scope of the deposition topics. There's nothing about HIPAA on there, and I think it's inappropriate.

MS. BLAZICH: I think it goes within the scope of the current topic, which is these documents, pages NEN22 to -- to 25, and I don't think it's appropriate to instruct her not to answer the question.

MR. DOBBS: Well, I'm going to, and I'm going

Page 52

to -- she has no foundation for the answer. She already told you she doesn't know why he was in the chart. It's a better question for Dr. Stefanko.

MS. BLAZICH: Well, that may be the case, but I don't have Dr. Stefanko right now.

Well, just for the record, my question is not asking her to speculate. I'm asking her based on her own personal experience and understanding of HIPAA.

I don't believe that any privilege applies. I believe that the objection is inappropriate. I believe that instructing her not to answer is inappropriate.

And if -- if and when this issue is addressed by the court, I reserve my right to redepose the witness as to that question.

MR. DOBBS: And that's fine. You can -- you can do that.

And I'll just make my record that I think the -- the question about whether or not this is -- this constitutes a HIPAA violation has deviated from the actual deposition topics, it's inappropriate, and has nothing to do with the current litigation, which is a medical malpractice case.

Q (BY MS. BLAZICH) All right. Going further down the list, we have a Mary Filippini. Filippini. I don't know how you pronounce that.

Page 53

A Filippini. You had it right.
Q Okay. Filippini.
So according to this record, at 9:53 a.m., Mary Filippini reviewed certain results pertaining to -- certain records pertaining to Douglas Schwartz, correct?
A Correct.
Q Who is Mary Filippini?
A She's a -- well, at this time she was a case manager that worked in the ER.
Q Was she an employee of the hospital at the time?
A Yes.
Q Do you know why Mary Filippini reviewed Doug Schwartz's medical records at 9:53 a.m. at 6- -- on -- on June 23rd, 2016?
A I don't have personal knowledge, but I know that it would be part of her normal role to review the ER patients that came through during the night, when she would come in the next morning, to review appropriate disposition of those patients. The case managers do that in the ER.
Q Okay. Are you aware of whether Mary Filippini dictated anything in the medical record for Doug Schwartz as a case manager?
A I'm not aware of anything, nor would I expect her to have anything in there.

Page 54

Q Okay. All right. If we go below, we see -- if we go just after Mary Filippini's name, we see Julia Price for David Garvey, M.D., and it indicates that she's scribing for provider at 10:24 a.m. on June 23rd, 2016 --
A Correct.
Q -- do you see that?
What is your understanding of what that means, scribing for the provider?
A My understanding is that they document things as things occur based on the provider's direct- -- direction.
Q So is it -- is it possible that she's finishing up some charting for the doctor from the previous -- well, from earlier that morning?
A Yes, very well could be.
Q Okay. And who's Julia Price?
A She is a -- she was a scribe at the facility.
Q Okay. So that was her primary job was to be a scribe?
A Correct.
Q Got it.
Just below that, we have Jessica Dullum.
Who is Jessica Dullum?
A She's an ER nurse.
Q And according to this record, Jessica Dullum reviewed Mr. Schwartz's medical records at 10:35 a.m. on

Page 55

June 23rd, 2016, correct?
A Correct.
Q And she appears to be looking at the same records Mary Filippini looked at and the same records that Dr. Stefanko looked at.
A Correct.
Q Any idea why Jessica Dullum reviewed these records at this time?
A Again, I don't have personal firsthand knowledge, but I do know that the ER nurses do charges, and they do that by reviewing charts to enter charges.
Q Does Jessica Dullum still work at the hospital?
A She does.
Q Does Mary Filippini still work at the hospital?
A She does, in a different role.
Q Understood.
In preparation for your deposition today, did you attempt to speak to Mary Filippini as to why she reviewed Douglas Schwartz's chart?
A No.
Q In preparation for your deposition today, did you attempt to speak to Jessica Dullum in terms of why she reviewed Douglas Schwartz's chart?
A No.
Q All right. About halfway down the page, there's

Page 56

an indication where it says encounter locked and encounter archived by agent; do you see that?
A Yes.
Q What does that mean, to have an encounter locked and archived?
A It's locked when they formally sign the chart.
Q So when the physician signs the chart, then the chart -- the encounter gets locked and archived?
A That's correct.
Q All right. So another question.
You -- you mentioned earlier that it was your guess that Jessica Dullum was reviewing the chart possibly to com- -- to compute charges.
Here we see the charges are being computed by agent at 6:05 a.m. on June 24th, 2016; do you see that?
A I do, but that's -- that's part of the automatic process of charges that come across through the system. Nurses -- we don't -- we have some things that aren't automatically charged, so they have to abstract that information from the chart and manually key it into another -- another program.
Q Okay. So it's possible that both were involved computing charges.
A Correct.
Q But not necessarily. Like -- like you said,

Page 57

you're not positive why Jessica Dullum was reviewing the chart.
A That's correct.
Q All right. Let me see. What else here?
All right. On the bottom of the page, it indicates post archive update by MEDHOST and then encounter locked agent.
Do you know -- what does it mean when it says post archived update?
A My understanding is if there's any -- if there's any changes to the log, it will archive that new update.
Q What do you mean changes to -- what log? This event log that we're looking at?
A No. Any changes into the system.
Q Got it.
So that would in- -- could include changes to billing or it could include changes to the patient chart.
A Correct.
And it's an automatic thing by MEDHOST, the system where it just updates the -- that document to show the changes.
Q All right. On page 24, NEN24, at the bottom we have on June 24th, 2016, 11:16 a.m., it indicates that Mr. Schwartz's chart was reviewed by Daniel Jones, D.O., Dr. Daniel Jones; is that correct?

Page 58

A Correct.
Q Do you know Dr. Daniel Jones?
A Through his employment here, yes.
Q Who is Dr. Daniel Jones?
A He's a ER physician and at the time was the ER medical director.
Q Do you also know if Dr. Jones is an own- -- owner or partner in Ruby Crest Emergency Medicine?
MR. BURTON: Speculation.
MS. MONTET: Join.
Q (BY MS. BLAZICH) If you know.
A I don't have firsthand knowledge of that.
Q Okay. And then going over to the next page, we see listed out all the different things in Doug Schwartz's chart that Dr. Jones reviewed, correct?
A Correct.
Q And it would appear to be these are the same parts of the record that had previously been reviewed by Dr. Stefanko.
A Correct.
Q Do you have any knowledge or understanding of why Dr. Jones reviewed Doug Schwartz's chart?
A No firsthand knowledge.
Q Did you attempt to talk to Dr. Jones about why he accessed Doug Schwartz's chart?

Page 59

A No.
Q Other than your attorney, did you speak to anyone at the hospital to try to determine why individuals who were not directly involved in patient care for Doug Schwartz -- why they were accessing the chart after the fact?
A No.
Q All right. Let me switch gears and go to topic number 11, which is the hospital policies and procedures pertaining to event reporting; and the topic pertains to sentinel events, but that's subject to a motion for protective order.
Let's see.
All right. Ms. Jones, this is the occurrence report policy at Northeastern Nevada Regional Hospital that was provided to my office.
Have you seen this document before?
A Yes.
Q And is this the document that you reviewed in preparation for your deposition?
A Yes.
Q Is it your understanding that this version of the occurrence report policy was in effect in June of 2016 when Douglas Schwartz was a patient at Northeastern Nevada Regional Hospital?

Page 60

A Yes.
Q All right. Based upon what it says in this policy, at the bottom of the -- the page, it indicates that all employees have an affirmative duty to report any event occurrence which is not consistent with the routine operation of the hospital and its staff or the routine care of a particular patient or visitor, or any situation which has a potential to cause harm to patients, visitors, or employees, including any adverse reaction or near miss, correct?
A Correct.
Q I'm sorry. I didn't hear you if you answered.
A Correct.
Q All right. All right. So section A here indicates that any person who discovers an unusual occurrence, adverse event, or near miss, good catch, is to notify the charge nurse, house supervisor, or department director and initiate a report in RL Solutions prior to the end of the work shift.
Did I read that correctly?
A Yes.
Q All right. When it says any person, does that extend to patients, visitors, vendors, things along those lines, or is this really just referring to hospital employees and staff?

Page 61

A It can be anybody.
Q Oh, it can be anybody?
Okay. But that in particular does encompass hospital staff, correct?
A Yes, correct.
Q What -- what is RL Solutions?
A RL Solutions is the name of our event reporting software program.
Q Okay. And is that something that's just accessible on some computer workstations and you can upload an event report into it?
A No. You complete the event report on the actual program.
Q Got it.
All right. So subsection B indicates that in the event of an incident of a serious or potentially serious nature, the administrator on call and quality and risk management director are to be notified immediately, right?
A Correct.
Q And subsection one underneath that indicates that that includes serious harm or the death of a patient, correct?
A Correct.
Q So an administrator on call, even if it's after hours, there would be -- always be an administrator on

Page 62

call for -- for the hospital; is that correct?
A Correct.
Q Is there always a quality and risk management director on call?
A No.
Q No. Okay.
So quality and risk management director is sort of available during normal business hours.
A They are administrator on call at times.
Q Okay. So does this policy require both an administrator on call and a quality and risk management director to both be notified immediately?
A I would say the language of this policy says "and," but that's not necessarily always the practice.
Q Understood.
The practice would be to what, notify either the administrator on call or the quality and risk management director?
A Yes.
Q At a minimum, one of those two individuals needs to be notified, correct?
A Correct.
Q And they would need to be notified by all staff members who were aware of an event involving serious harm or the death of a patient, according to the policy.

Page 63

A Correct.
Q Okay. Page three of four of this document -- and just for the record, let's -- let's have this occurrence report be Exhibit 4.
(Plaintiff's Exhibit 4 was marked for identification by the reporter.)
Q (BY MS. BLAZICH) According to section number three at the top, any event or occurrence report is to be completed within 24 hours; is that correct?
A Correct.
MS. BLAZICH: All right. Let's mark as Exhibit 5 the -- I think this is an occurrence report. It's Bate stamped OCC-RPT000001 through 5, I believe.
(Plaintiff's Exhibit 5 was marked for identification by the reporter.)
Q (BY MS. BLAZICH) Ms. Jones, have you seen this document before?
A Yes.
Q Did you review this in preparation for your deposition today?
A Yes.
Q Are you familiar with this format that the document has been printed out in? Is -- is this a document from RL Solutions?
A It is.

Page 64

Q Okay. So this is what an event report completed in RL Solutions would look like when printed out; is that fair?
A Yes.
Q All right. And this occurrence report indicates that it is involving an unexpected patient death, correct?
A Correct.
Q Do you know who completed this incident report -- or occurrence report?
A My understanding is it's Donna Kevitt.
Q Is there any name of somebody signing off on this report or indicating who submitted the report?
A No. I'm -- I'm making that determination by the report itself.
Q Okay. What -- what are you relying on to make the determination that Donna Kevitt was the one who completed this report?
A She mentions the staff members present for the code were Dr. Garvey, myself, and she listed all of the people that were there, employees, except for Donna Kevitt's name that's not listed, so I have to assume Donna Kevitt was the "myself."
Q Okay. There is no name anywhere on the report indicating definitively who -- who prepared it.
Am I correct about that, or am I missing it?

Page 65

A No. That's correct.
Q Are these reports intended to be anonymous?
A They can be submitted anonymous, or you can submit them under your -- your identifying -- 34 number we call them here at the hospital.
Q Do you know if this particular occurrence report was submitted anonymously or not?
A I don't.
Q Okay. Did you speak to Donna Kevitt to determine one way or the other if she's the one who prepared this occurrence report?
A No.
Q Did you -- other than speaking with counsel, did you in any -- do any investigation to determine who authored this occurrence report?
A No.
Q Are you aware of whether or not any other occurrence reports were created pertaining -- by any other staff members pertaining to Doug Schwartz?
A Not to my knowledge, no.
Q Okay. Did you look to see if there were other occurrence reports generated by other hospital staff?
A No. I don't have access to that.
Q Okay. So you -- you've only reviewed this occurrence report, correct?

Page 66

A Correct.
Q And you did not go back to see whether there were any other occurrence reports related to Douglas Schwartz's care; is that fair?
A That's correct.
Q Okay. So you don't know as you sit here today one way or the other whether other occurrence reports pertaining to Doug Schwartz's care exist in the hospital system.
A That's correct.
Q The -- the occurrence report policy that we went over a minute ago requires all employees to prepare an occurrence report when there is an unexpected patient death, correct?
A Correct.
Q All right. Moving right along.
A Can I ask a question about your last question?
Q You want to ask a question about my question? Sure.
A You said the policy says all employees have to report an event.
Are you -- were you asking me if all employees involved in this should have all filled out an occurrence report?
Q No. I'm asking you if that's -- if the policy

Page 67

says that all employees should report an event if -- in the case of an unexpected patient death.
A Yes. But just one needs to be done, not every employee that was there. I guess that's where I got your question confused.
Q Hold on.
Let me -- my question, I believe, was that the policy indicates that all employees have an affirmative duty to report an event, including an unexpected death of a patient.
A Yes. So -- but we wouldn't have all employees do separate ones on the same event. They would -- like the charge nurse or the primary nurse would be doing it for an event. We don't need one from each of them. That's not the expectation.
Q Well, I didn't ask you that question.
My question is --
A Okay.
Q -- about specifically what's in the policy.
The policy indicates, and I believe you've answered it, that --
A Okay.
Q -- all employees are to complete an event report when there's an unexpected patient death.
That's what the policy says, correct?

Page 68

MR. DOBBS: I'm just going to object. If -- if you wanted to know just what the language was, then I don't know why you took her deposition. She just told you what the policy and practice is of the hospital.
So I'll object to the -- the line of questioning is argumentative. She gave you the answer, so I don't think you -- you're entitled to change her answer to fit your question.
MS. BLAZICH: Well, I think the -- she's answered my question previously, and the response was nonresponsive, so I'll object that it was nonresponsive cause it was beyond the scope of the question.
Q Ms. Jones, I'm not intending to argue with you.
Do you feel like I'm arguing with you?
A No. I just thought about your question and then was wondering if you were asking me if I would expect all employees to fill out, so I just wanted to clarify --
Q Right. And so my ques- --
A -- I understood the question.
Q My question pertains to what the written policy says specifically.
And I think you've answered that, correct?
A Correct.
Q Okay. All right. Let me move on to these crash cart logs.

Page 69

All right. Bear with me as I try to locate that.
All right. Ms. Jones, I'm showing you a document that was produced from the hospital that states crash cart checklist at the top; do you see that?
A Yes.
MS. BLAZICH: All right. And let's mark this as Exhibit 6, I believe.
(Plaintiff's Exhibit 6 was marked for identification by the reporter.)
Q (BY MS. BLAZICH) Have you seen this document before?
A Yes.
Q And is this something that you reviewed in preparation for your deposition today?
A Yes.
Q So explain -- can you explain to me what this document shows.
A So it shows the crash cart that we have located in room 11/12 for the month of June, each day that it was checked, what elements were checked, and a signature of who checked it.
Q All right. So this log sheet only pertains to room 11/12.
A That crash cart in 11 and 12, yes.
Q Got it.

Page 70

Are 11 and 12 -- are they two beds in the same room --
A Yes.
Q -- and that's why there's two numbers?
A Yes. There's a curtain that divides those two rooms.
Q Got it.
So there's one crash cart that services I guess beds 11 and 12?
A Yes.
Q Got it.
And then the date on the far left-hand side, those are the days -- that's the date in June, 1 --
A Yes.
Q -- through -- well, there's nothing for 31 cause there's not 31 days in June.
But that would be the date in June that the crash cart was checked.
A Yes.
Q All right. Can you tell on the 2- -- let's say the 21st, 22nd, and 23rd, the R.N.'s signature?
I'll try and enlarge it for you.
Can you read any of those signatures? Or do you know who these individuals are right about here?
A So I see Kathy Pruitt, R.N. on the 22nd and 23rd.

Page 71

And maybe the 21st looks like maybe Sarah Johnson's signature.
Q Are those individuals still employed at the hospital?
A Yes. Both of them are.
Q So is it the nurse's responsibility to check the crash cart in the ER in room 11 and 12?
A Yes.
Q Okay. Is it -- is it just whoever is on shift -- on like day shift or night shift who has that responsibility? Would it be the charge nurse?
A The -- the charge nurse will do it or delegate who's going to do it.
Q Got it.
And then the manager supervisor initials that it's been completed?
A Correct.
Q Who is the manager supervisor signature around the 21st, 22nd?
A Sue Olson.
Q And do you -- do you know when the supervisor or manager initials it, are -- are they just initialing that it's been done by the R.N., or do they go back in to double check what the R.N. has done?
A No. They're just making sure someone has

Page 72

completed it in that 24 hours.
Q Do you know, is a crash cart the same thing as a trauma cart at your hospital?
A No, they are not.
Q They're not?
A No.
Q All right. How -- how are they different?
A The contents are different. The use of them are different. We only have trauma carts in the ER. Crash carts are throughout the building.
Q Oh, so in the ER, they're trauma carts?
A Yes.
MR. DOBBS: No.
THE WITNESS: No. ER has trauma carts and crash carts.
Q (BY MS. BLAZICH) Okay. And so I understand what you said, that there's different equipment in -- in each one.
Could you generally -- I don't need an exhaustive list of the equipment, but generally could you tell me what equipment is in a trauma cart versus what equipment is in a crash cart.
A A crash -- generally a crash cart is going to have the equipment needed for the actual cardiac or respiratory arrest situation, where a trauma cart is going

Page 73

to have many different traumatic situation equipment available, burns, lacerations, contusions, different things.

Q Okay. Thank you for that.

Let me briefly go back to the occurrence report.

Do you see -- do you see here where it indicates trauma cart open?

A Yes.

Q Is it your understanding -- or do you have an understanding whether this occurrence report is in fact referring to a trauma cart --

A Yes.

Q -- or if it's referring to a crash cart?

A No. A trauma cart.

Q Okay. And -- and how do you know that it's actually referring to a trauma cart and that it's not just using the terms interchangeably between trauma cart or crash cart?

A Cause I don't believe anybody would use those terms interchangeably because we know they're all different things.

Q I appreciate that. I would use them interchangeably cause I didn't know that they were two separate things.

A Sure.

Page 74

Q But you're -- you're telling me that, you know, it's common knowledge at the hospital that a trauma cart is different from a crash cart.

A Yes.

Q Okay. And this occurrence report appears to be referring to a trauma cart in particular, not a crash cart.

A That's correct.

Q All right. Are you aware, Ms. Jones, on whether or not Northeastern Nevada Regional Hospital has a written policy in -- for trauma cart maintenance and storage?

A It does not.

Q Would the contents of a trauma cart -- would the crash cart policy apply to a trauma cart as well as a crash cart?

A No.

Q Okay. A crash cart policy only refers to crash carts.

A Correct.

Q Got it.

So the log that we have looked at -- I'll put it up on the screen again.

The log that I had put on, which I believe was Exhibit 6, this is -- no. Sorry. That's the wrong one.

Let me see if I can find the right one.

Page 75

There it is.

All right. This document, which was Exhibit 6, the crash cart checklist, this pertains to the crash cart, correct, not the trauma cart?

A Correct.

Q Does the hospital keep a written record of trauma cart checks?

A I did see a log that they keep, not the same as this for the crash carts. I believe it was to check for outdates monthly.

Q And by outdates, you mean things like expired medications or expired equipment?

A Equipment, yeah.

Q Equipment.

Okay. So you believe that there's something that resembles a monthly log of trauma cart checks, correct?

A Correct.

Q Did you happen to see one for June of 2016?

A I would have to look at the ones provided if that was the month that I reviewed.

Q Okay. As you sit here today, what can you recall about trauma cart logs that you reviewed?

A Just they were done monthly, that they were checked by someone for outdates.

Q Okay. And what was the time period that you

Page 76

reviewed?

A I would have to look to be sure, to be accurate.

Q Did you review that -- the trauma cart logs specifically in preparation for -- for your deposition today or for some other reason?

A For this deposition.

Q All right. And -- and you don't know one way or the other if you reviewed trauma cart logs for on or around June of 2016?

A I did. I was just provided them.

Q Oh, okay.

MR. DOBBS: Yeah. We saw them on your screen earlier, so it's -- it's what you -- you put up on there on the screen.

MS. BLAZICH: It is?

MR. DOBBS: Yeah. It popped up. It was the trauma cart update monthly logs. I saw it pop up on your screen share a little bit ago.

MS. BLAZICH: Mm. Let's see.

No. What accidentally popped up on my screen was the call schedule.

MR. DOBBS: No. It was the trauma cart logs. I saw that pop up, and so I thought you were going to ask her about it.

But she's been provided it now. She's looking at

Page 77

it. The Bates numbers are --
MS. BLAZICH: Yeah.
MR. DOBBS: -- TCLOGS1 through 6.
MS. BLAZICH: All right. Well, let's see.
So it's not this, cause that's the crash cart log.
Did you just see it pop up recently or --
MR. DOBBS: I saw it when you -- I think when you were doing the call schedule, that popped up, so you must have clicked on that one before you did the other one.
MS. BLAZICH: Oh, on accident maybe I clicked on it?
MR. DOBBS: Yeah. So it wasn't like we went over it. It was that it was an accidental pop-up.
MS. BLAZICH: Got it. Let me see.
All right. Hold on.
They're not -- is it part of this?
MR. DOBBS: No.
MS. BLAZICH: Oh, see --
MR. DOBBS: That's the inventory list.
MS. BLAZICH: All right. Well, I'm wondering if it's part of this exhibit.
MR. DOBBS: It was I think served on Wednesday or something.
I can show you the -- what it looks like on

Page 78

the...
MS. BLAZICH: Oh, okay. I do remember seeing that somewhere.
Sorry. I'm trying to find it.
It's not part -- I think it is part of this exhibit.
There it is.
Is that it?
THE WITNESS: Yes.
MS. BLAZICH: Got it. Okay. All right.
So let's -- let's mark this as Exhibit 7.
(Plaintiff's Exhibit 7 was marked for identification by the reporter.)
Q (BY MS. BLAZICH) And these are the monthly trauma cart logs.
A Correct.
Q All right. And it shows trauma cart ED 11, trauma cart ED 12, and we see the name Julia.
A Yes.
Q Okay. And at the top, this is for January of 2016, correct?
A Correct.
Q And just to be clear, are there two trauma carts in the emergency department for beds -- one for bed 11 and one for bed 12?

Page 79

A Yes.
Q Okay. So there's two separate trauma carts.
A Yes.
Q Got it.
All right. So this indicates that monthly crash cart outdates are recorded on the daily crash cart checklists.
A Correct.
Q Okay. So crash cart stuff is on the daily crash cart checklist.
This is just monthly outdates.
A Correct.
Not on the crash cart. Just the -- these other carts that they have in their department.
Q Right.
So when a -- a staff member is checking for outdates, what does that entail? Just throwing out any outdated materials or replacing them as well?
A They would take out anything expiring that month and then replace it with something else.
Q With a similar item that's not expired, correct?
A Correct. Or coming up expired.
Q Is part of this monthly outdates check -- does that include checking to make sure that all the equipment that's supposed to be in the trauma cart is in the trauma

Page 80

cart?
A I don't have firsthand knowledge of that; but yes, that is the practice.
Q So -- well, what do you mean when you say you don't have firsthand knowledge of it?
A Well, I've -- I've never performed these checks like I have a crash cart; but it is my understanding that when they check for outdates, they are looking for the contents in the cart as well.
Q And what is that understanding based on?
A Just my knowledge of their -- their working operations in the ER. They do the same on the dressing cart and the fridge.
Q Have you observed staff in the ER check trauma carts for monthly outdates?
A Not the trauma cart, no.
Q Have you -- you -- and you haven't seen any kind of a written policy that talks about stocking a trauma cart, correct?
A No, no policy.
Q Have you had discussions with staff in the ED about the procedure for doing monthly outdates for a trauma cart?
A Not staff. I asked Jen, the director of the emergency department.

Page 81

Q Sorry. Who did you ask?
A Jennifer Tingle, the director of the emergency department.
Q Okay. When did you ask Jennifer Tingle?
A During this deposition preparing time.
Q Okay. So you talked to her about how the monthly outdates are done pertaining to the trauma carts in the emergency department.
A Yes.
Q And what did she tell you?
A That they check them every month for the outdates and that they're stocked, and they would replace something if they took something out that was expiring.
Q Okay. So did she tell you anything about what happens during the month if items are used out of the trauma cart?
A That if they're used, the nurse that uses them would replace it.
Q Okay. So is it your understanding then that it is the responsibility of the nurse in the emergency department to make sure that any equipment that is removed from the trauma cart is replaced immediately or as soon as possible in the trauma cart?
A I would say as soon as possible, yes.
Q Right. It's not replaced on a monthly basis.

Page 82

It's supposed to be replaced as it's used.
A Ideally, yes.
Q Okay. All right. So here we have February, and I'm assuming it's for 2016 as well, even though it doesn't have a year on it.
Ms. Jones, is it your understanding that this trauma cart list for monthly outdates in February, that this is for 2016?
A That is my understanding as well.
Q And here we -- we don't have anybody signing completing the trauma cart checks for trauma carts 11 and 12 in February.
A That's correct.
Q All right. Here we have March of 2016, and it indicates that the trauma cart -- trauma cart 11 -- for ED 11 was checked, I think it says 3-24-16?
A Yes.
Q And then the trauma cart for ED 12 was checked 3-25-16, correct?
A Correct.
Q In April of 2016, we just have checkmarks; we don't have names.
A That's correct.
Q Is there any way to tell here who completed trauma cart checks in April of 2016?

Page 83

A No.
Q All right. In May of 2016, we have some initials for trauma cart ED 11 and trauma cart ED 12.
Do you know whose initials those are or what that says?
A I don't think they're initials.
Q What do you think it says?
A I think it says Burt.
Q Burt.
Does Burt mean something to you other than Ernie's friend?
A Yeah. I'm guessing it says Burt. I haven't ever seen Burt's signature before.
But, yeah, Burt works in the ER.
Q Oh, okay. I don't see an "r." I just see B-u-t, "But."
A And I don't know of any "Buts" in the ER, but I do know a Burt. That's why I'm -- I'm stretching to Burt.
Q Okay. All right.
A I think on the -- the pediatric cart one, on that same one, that's --
Q Yes.
A -- where I see Burt a little bit better.
Q I see. Yeah, I could see Burt there.
Okay. Thank you.

Page 84

On June 2016, we have trauma cart ED 11, we have a signature, and it appears that it was checked on June 23rd, 2016, correct?
A Correct.
Q And the trauma cart ED 12 was also checked on June 23rd, 2016.
A Correct.
Q So this appears to me to be immediately after Mr. Douglas Schwartz's treatment in the ER.
A Correct.
MS. BLAZICH: Does anyone need a break? Or we want to just get it over with?
MR. DOBBS: Well, a quick bathroom break maybe?
MS. BLAZICH: Okay. Let's take a quick bathroom break. I'm wrapping it up, I promise.
MR. DOBBS: Are you? Okay.
MS. BLAZICH: Yeah. But go ahead, let's take a break.
MS. ULREY: We're off the video record at 4:12 p.m.
(Recess.)
MS. ULREY: We are back on the record.
The time is 4:18 p.m.
You may proceed.
Q (BY MS. BLAZICH) Ms. Jones, let me just remind

Page 85

you that you're still under oath.
A Yes.
Q During the break were you able to determine who authored the occurrence report that I had showed you earlier pertaining to Douglas Schwartz?
A Yes. I talked to the quality department, and Donna Kevitt authored the occurrence report, and there were no other occurrence reports on this case.
Q Got it. Thank you.
A You're welcome.
Q Just to wrap up a couple more questions real quick about the trauma cart.
Are you aware of any type of inventory list for what is meant to be in a trauma cart?
A Just what I was shown in a document.
Q Okay. Is that -- hold on. No, that's the wrong one.
Is this it?
A Yes.
Q Okay. And so this shows what is I guess meant to be at the top of the trauma cart?
A Yes.
Q And where -- where did this photograph come from, if you know.
A Whoever created this document must have took

Page 86

pictures of the ideal trauma cart and how it should look and put them on there for a visual aid for them to stock it.
Q Okay. So is this -- this document on the screen right now, is that something that exists like in a binder somewhere at the hospital, where staff can refer to this document to see what is supposed to be in the trauma cart and where it's supposed to be?
A Yes. In the ER there's a binder.
Q Okay. Great.
And so this photograph is in that binder, correct?
A Correct.
Q Okay. I just wanted to make sure somebody didn't take a photo of it and send it to me for the purpose of the lawsuit or if the photo is a regular part of what's in that binder.
A No. It's a regular part.
Q All right. So this shows, for trauma cart 11, what is supposed to be at the top of the cart.
And then there's a blank page. Tyson, do you know, is that just a blank page?
MR. DOBBS: Yeah. This is just an exact copy of this trauma cart inventory list that sits on each trauma cart, and so it -- we just photocopied exactly how it is,

Page 87

and --
MS. BLAZICH: Got it.
MR. DOBBS: -- so that's how you have these blank pages. Sorry.
MS. BLAZICH: Okay. No problem. I just wanted to make sure it wasn't supposed to have something on it.
Q All right. And then we've got trauma cart 11, drawer one. This is what's meant to be in the trauma cart, correct?
A Correct.
Q And is this a picture of drawer one?
A That is a follow -- that picture is the one that follows trauma cart 12, top of cart?
Q I have it right after trauma cart 11, drawer one.
A Okay. Then yes, that would be what would be in drawer one.
Q All right. Then we have trauma cart 11, drawer two, and there's a photograph there, correct?
A Correct.
Q And there's a couple items that are crossed out on that list.
Do you know why that's crossed out?
A I don't have firsthand knowledge, but I -- based on my knowledge, we can't keep medications in this cart.
Q All right. So NS 500 cc, that's normal saline,

Page 88

500 cc's?
A Yes. But those are considered medications, and medications have to be stored differently.
Q All right. It looks from the picture that there's bags of saline in there.
A That's right. I'm sure that that picture came from when they originally put out this list where they were putting NS. My guess is someone came along and noticed that that shouldn't be in there, and they crossed them off.
Q All right. So is -- is this document that we're looking at, these yellow trauma cart pages, this is what that trauma cart binder looks like right now in the ED?
A Yes.
Q Do we know if this is how it looked in June of 2016?
A I have to as- -- I believe this is the same, but it's been the whole time in existence to my knowledge.
Q So -- but do we know, were these parts that are crossed out on the page -- were these crossed out in June of 2016, or did they get crossed out after?
A I don't know that.
Q Okay. So they may not have been crossed out in June of 2016.
A There's potential, yes.

Page 89

Q Okay. You don't know one way or the other.
A I don't.
Q All right. Trauma cart 11, drawer three, again, this is a list of what's supposed to be in there and a photo, correct?
A Correct.
Q Trauma cart 11, drawer four, this is a list of what's supposed to be in drawer four, correct?
A Correct.
Q This is a photograph presumably of what is supposed to be in drawer four, correct?
A I would say three and four.
Q Three -- drawers three and four?
A Well, just cause there's two photos following talking about three and four.
MS. BLAZICH: Got it.
All right. And I'm not sure I -- if I marked this, but I think this -- this document is going to be Exhibit 6 [sic], the trauma cart inventory lists.
(Plaintiff's Exhibit 8 was marked for identification by the reporter.)
Q (BY MS. BLAZICH) All right. So these are from trauma cart 11, drawer five, a list of equipment that is meant to be in there, correct?
A Yes.

Page 90

Q And then somebody's written in temperature Foley cath?
A Yes.
Q Do you know when that was written in?
A No.
Q Do you know whether it had temperature Foley cath -- whether that was written in in June of 2016 or not?
A I do not know.
Q I guess this is a photo of what drawer five is meant to look like?
A Yes.
Q Okay. Trauma cart 11, drawer six, here is a list of what is supposed to be in drawer six, correct?
A Correct.
Q And the parts that are crossed out or written in, do you have any idea if those changes were made before or after June of 2016?
A No, I do not.
Q Presumably this is a photograph of what drawer six is meant to look like, correct?
A Correct.
Q All right. Now this is something pertaining to chest tube bags.
Trauma cart room 12 inventory list, do you have

Page 91

that in front of you?
A Yes.
Q Well, first of all, let me ask you this.
Do you know whether trauma cart 11, trauma cart 12, or both, were utilized during the care and treatment of Doug Schwartz?
A I do not have firsthand knowledge of that.
Q Do you know -- Donna Kevitt's occurrence report notes that there was equipment missing from the trauma cart.
Do you know what equipment Donna Kevitt was referring to in that occurrence -- in that occurrence report?
A I believe I read that portion of her testimony.
Q Okay. What's your understanding of what equipment Donna Kevitt was referring to when she mentioned equipment in the trauma cart not being available?
A If I recall correctly, it was the Bougie.
Q Bougie.
In preparation for your deposition today, did you talk to Donna Kevitt about what -- what she was referring to in the occurrence report where she indicated that the trauma cart was open and not fully stocked?
A No. I have had no communication with Donna Kevitt.

Page 92

Q Does Donna Kevitt still work at the hospital?
A No, she does not.
Q Did you make any attempts to communicate with Donna Kevitt?
A No, I did not.
Q Does the hospital have contact information or last known contact information for Donna Kevitt?
A We would have last known in her file, yes.
Q Okay. And -- but you didn't make any attempts to -- to con- -- reach out to her last known address or phone number, correct?
A No, I did not.
Q So as you sit here today, are you -- other than the Bougie that you're referring -- that you mentioned from her deposition, do you know one way or the other if that's an exhaustive list of what Donna Kevitt was referring to as being missing from the trauma cart?
A That's all to my knowledge, based on what I reviewed.
Q Okay. So your information's coming from your review of the deposition transcript, correct?
A Correct.
Q And other than what's in the deposition transcript, you have no other knowledge about what may -- what equipment may have been missing from the trauma cart

Page 93

as indicated by Donna Kevitt in the occurrence report.
A No.
Q Is that correct, that other than what's in the deposition of Donna Kevitt, you don't have any other information about what may have been missing from the trauma cart?
A I --
MR. DOBBS: Foundation.
MS. BLAZICH: Sorry. I didn't hear that.
MR. DOBBS: Objection, foundation.
Q (BY MS. BLAZICH) Okay. Let me -- let me try to reask it, Ms. Jones.
What I'm -- what I'm trying to ask you is -- I understand that you read a portion of Donna Kevitt's deposition and that you concluded from that that a Bougie may have been missing from the trauma cart involved in Doug Schwartz's care.
Is that correct so far?
A Well, not that it was missing from the trauma cart. She didn't say that in her deposition. She said she had to get it from the wall.
Q Okay. So was there anything from the deposition where you were able to determine what -- what if any equipment Donna Kevitt is referring to in her occurrence report where it indicates that the trauma cart is open and

Page 94

not fully stocked?
A No.
Q Okay. And other than what's in that deposition, do you have any other knowledge as to what may have been missing from the trauma cart that was utilized during Doug Schwartz's care and treatment?
MR. DOBBS: Objection, lacks foundation.
Go ahead.
THE WITNESS: Say the question again.
Q (BY MS. BLAZICH) Sure.
So I understand you read Donna Kevitt's deposition, but you have not spoken to her, correct?
A Correct.
And I think I was only provided parts of her deposition.
Q And -- and that's fair enough.
The occurrence report indicates that the trauma cart is open and not fully stocked, correct? That's what it says in the occurrence report.
A Correct.
Q Do you know what equipment Donna Kevitt is referring to when she said that in the occurrence report?
A No.
Q Okay. All right. Let's finish with this document.

Page 95

So this is the top of trauma cart 12. This is what is supposed to be in there, correct?
A Yes.
Q This is a photograph of what the top of the cart is meant to look like.
A Correct.
Q All right. Trauma cart 12, drawer one, this is a list of what is meant to be in drawer one, correct?
A Correct.
Q Blank page.
And there's no photograph for drawer one, so then we go to drawer two, and this -- this basically seems to be exactly what we looked at for trauma cart 11; is that fair?
A I -- I would have to cross-reference them to see if they were exact; but same concepts, yes.
Q I mean they're both -- they're both trauma carts, and theoretically they should be stocked the same way, correct?
MR. DOBBS: Foundation.
THE WITNESS: I can't say that because I don't know if they use -- one cart is more geared towards ortho, one cart's more geared towards burn. I could not say that they -- that they should be exactly the same.
Q (BY MS. BLAZICH) All right. Well, why don't you

Page 96

take a moment to look at the inventory lists for trauma cart 11 and 12 from the top of the cart to drawer one, two, three, four, five, six, and if there's a drawer seven, and just let me know if you see any -- any differences at all between trauma cart 11 and trauma cart 12, or are these two trauma carts basically the same thing?
A I would say that there is a lot of likeness, but there is some differences.
Q Okay. Do you know why would trauma cart 11 be different from trauma cart 12? What's your understanding?
A I don't have firsthand knowledge of the utilization of these carts in one room versus the other. Just what I said earlier, my -- my own personal clinical knowledge would be maybe one is set up for a specific type of trauma versus the other one for a different type.
Q Based on the records that are in front of you, can you tell what type of trauma trauma cart 11 is set up for and what type of trauma trauma cart 12 is set up for or intended for?
A No. I've never been a trauma nurse, so I could not make that determination, no.
MS. BLAZICH: All right. All right. Let me go to -- this is -- we'll mark this as Exhibit 9. This is the audit trail produced by the hospital.

Page 97

(Plaintiff's Exhibit 9 was marked for identification by the reporter.)

Q (BY MS. BLAZICH) Ms. Jones, I want to quickly go through it. We've been here a long time.

Have you reviewed this document in preparation for your deposition today?

A I have.

Q Okay. And are you aware of this document indicating that parts of Doug Schwartz's electronic medical record were accessed by separate individuals? And I'll -- I'll run through them.

Dr. Robert Stefanko. Does this document show that Dr. Robert Stefanko accessed Mr. Douglas Schwartz's patient chart?

A Yes.

Q Does this document show that Dr. Daniel Jones accessed Doug Schwartz's chart?

A Yes.

Q Does this record show that Dr. Donald Crum accessed Mr. Schwartz's chart?

A Sorry. This one's longer. I'm trying to find it.

Q No. It's okay.

A Make sure I'm not going off a memory that is inaccurate.

Page 98

Yes, it does show Dr. Donald Crum accessed it.

Q What page are you looking at to see Dr. Crum's name?

A Page eight -- or -- yeah, page eight.

Q Okay. So what is your understanding of how this document, this audit trail, was created? Is this something that you can -- that can be accessed at the hospital? Somebody's able to pull it -- pull up the audit trail for everybody who logged into a patient chart and identify the workstation?

A So this specific audit trail appears to be printed from MEDHOST EDIS system, which is the ER-specific system.

Q So --

A And, yes, it's a report that they can generate to see who -- what events occurred in this patient's record in the EDIS system.

Q All right. And so it -- it also includes information about what workstation the chart was accessed from, correct?

A Correct.

Q Are you able -- or is there a way to know, based on the workstation IDs and the -- you know, whether it says MEDHOST or whether or not there's like an IP address, whether or not those workstations are inside of the

Page 99

hospital or outside of the hospital?

A I didn't see any on this in my review that would give me indication that it was outside of the hospital.

Q Do you know, in June of 2016, did physicians have remote access to patient charts from outside of the hospital?

A I -- I believe they did. I don't know exact dates, but I do -- I do believe we had remote access in 2016.

Q Okay. So that means the physician would be able to be off-site, not at the hospital, and still pull up a -- a patient chart, correct?

A I don't know about EDIS. But MEDHOST, our main EMR, they had remote access to.

Q So then --

A I don't know if you can remote into the emergency, directly into their system.

Q Okay. Cause the emergency department has a separate system.

This -- the document we're looking at is the emergency department system, correct?

A Correct.

Q Okay. And so you're not sure as you sit here today whether remote access to the emergency department electronic medical records system was available in June of

Page 100

2016.

A That's correct.

Q Do you know one way or the other, when Dr. Robert Stefanko accessed the chart, whether he did it from inside the hospital or outside the hospital?

A By my understanding, it would be inside the hospital from NNRH ER 42 workstation.

Q So would you expect all in- -- all workstations inside the hospital to be similarly designated NNRH ER and then a number for the workstation?

A I can't verify all workstations in the hospital say that. We have over 300 computers here, so I don't know how the naming convention is on all of them.

Q All right. When there is an IP address instead of a workstation -- so like, for example, right there, where we see an IP address, do you know one way or the other if that signifies that that access came from outside of the hospital versus inside of the hospital?

A I would say it would not, just because other people who have accessed it and has an IP address, they wouldn't have remote capabilities. They -- you have to be in a group to be able to remote access any of our stuff, not -- like nurses that work the floor cannot remote into our systems. Doctors can. There's certain ones of us that have those rights. And we have people on this list

Page 101

that don't have those rights that have an IP address listed.
Q Okay. So generally, treating nurses do not have remote access to the patient chart?
A They do not.
Q All right. But generally physicians would.
A Yes. They have the potential to have remote access.
Q Okay. And so when we see people's names, like Mary Filippini or Cynthia Fus or David Garvey, this is indicating that they have electronically accessed the chart, and this is the name of the person because the computer is recognizing that it's coming from this individual.
A That's correct.
Q All right. There are a few names that I saw in that audit trail. I just want to ask you if you know who they are.
A Okay.
Q I saw an Angie Barnett.
A Angie Barrett? She is a --
Q Barrett?
A -- coder.
She's a coder.
Q Jessica Riley?

Page 102

A The name sounds familiar. Let me look it up.
I believe she works in mater- -- not material -- medical records, or worked in; I don't think she works here anymore.
Q Greg Halton, who is that, if you know.
A Medical records.
Q Kimberly Jackson?
A ER nurse.
Q Edward Johnson?
A ER director at the time.
Q Renee Landon?
A She worked in medical records.
Q Bridget Whalen?
A She's our revenue integrity coordinator.
Q All right. Okay. Have I given you a full opportunity to answer all of my questions today, Ms. Jones?
A I believe so.
MS. BLAZICH: Okay. I don't have any other questions.
EXAMINATION
BY MR. BURTON:
Q Ms. Jones, my name is James Burton. I represent REACH Air.
How are you?

Page 103

A I'm good. How are you?
Q Good.
Can you hear me okay?
A I can.
Q All right. I've got a couple follow-up questions based on your testimony.
Do you have the code sheet in front of you?
A I can get it.
Q Okay. That would be helpful.
And -- and as a preface, a lot of my questions may jump around just because I'm following up on some issues that were raised by Ms. Blazich.
A Sure.
Q All right. The code sheet, you've got that in front of you now?
A Yes.
MR. DOBBS: Page 33, right?
MR. BURTON: Yes. NEN33. Thanks, Tyson.
THE WITNESS: Okay.
Q (BY MR. BURTON) Earlier you were asked about the placement of the IV.
Do you recall that?
A Yes.
Q Do you have an understanding as to when this code event occurred in relation to when Mr. Schwartz first

Page 104

pres- -- arrived at the emergency department, how many hours it was different?
A So they -- they marked the time of arrest as 0035, and his arrival was at 2051.
Q And do you see the arrival time 2053 at the top of 33? Maybe I'm reading that wrong.
A Yes, yes. 2053.
Q Okay. All right. Would it -- based on your experience, do you believe, looking at this code sheet, when it says IV present site 2- -- let's see, 20g right hand on the right side; do you see that?
A Yes.
Q If you look at the code sheet, can you tell for sure when that IV was placed?
A No.
Q Would it surprise you if the IV was placed as part of the intubation, or do you think it would have been placed earlier?
A I would think that the one that says IV present would have been placed earlier.
Q And do you have -- based on your review of the records, do you have any idea as to when that IV would have been placed?
A So based on Donna Kevitt's documentation on page 10, she put 2120 maintain field IV, which tells me that

Page 105

the field EMS crew placed that IV, and they maintained that IV that they started, which was a 20 gauge in the left wrist, which is actually the one over here that says they started.

Q There's -- is there a difference between the field EMS and the REACH critical transport crew?

A By this charting, I -- I don't know. I don't know if he was brought in by Elko County ambulance EMS. That's my understanding, cause I don't believe REACH has a ground transport for calls. The Elko County ambulance brought him in. REACH came to help provide transport to another facility.

Q All right. There were many questions that were asked -- let me back up.

If the -- if the -- if the IV was placed in field and REACH did not provide in-field transport from the site of the accident to the hospital, does that help you understand as to who placed the IV, whether it was REACH?

A I would say it would not be REACH that placed the IV.

Q All right. Ms. Blazich asked you many questions and showed you records regarding the medications that were administered as part of the intubation attempt.

Do you recall that?

A Yes.

Page 106

Q Does the hospital have any policy or procedure that you're aware of that would pre- -- that would dictate where those medications need to come from, meaning from the hospital or from REACH?

A No.

Q So if the -- if the rocuronium and the ketamine had come from REACH, would that have been improper?

A No.

Q Same question with respect to the materials that were used, the instruments, the tubing, et cetera, for the intubation attempt, is there any policy from the hospital that dictates that that -- those materials and instruments need to come from the hospital?

A No.

Q So if REACH instruments or tools or equipment were used, would that have been improper?

A No.

Q Let me talk to you a little bit about this code event.

From the hospital's perspective, was it improper for the REACH crew to assist in this intubation and the intubation attempt and the code event that you talked about?

A No.

Q For example, would the hospital consider REACH'S crew's assistance in the code or the intubation attempt an assault on Mr. Schwartz?

A No.

Q Would the hospital consider REACH's assistance in the code event or the intubation a battery, a physical battery, of Mr. Schwartz?

MS. BLAZICH: I'm going to object that it lacks foundation for the question.

MR. BURTON: I agree that the -- the battery allegation's lack of foundation. I'm just teasing, Shirley.

MS. BLAZICH: You're --

MR. BURTON: All right. I'm going to strike that. You can strike that from the record. It's late. It's Friday afternoon.

Q Let me ask the question again.

From the hospital's standpoint, did Mr. -- did the REACH's crew's assistance in -- in the intubation attempt and the code response constitute a battery?

MS. BLAZICH: Objection, lacks foundation.

Q (BY MR. BURTON) You can answer.

A No.

Q From the hospital's perspective, did REACH's assistance in the intubation and the code event constitute a false imprisonment of Mr. Schwartz?

Page 108

MS. BLAZICH: Same objection.

Q (BY MR. BURTON) You can go ahead and answer.

A No.

Q In your experience as -- remind me, are you -- we've had four -- three or four people deposed today, and I can't remember what your background was.

Are you a nurse in addition to your director of the cardiopulmonary group?

A Yes.

Q Okay. And you have ER experience as a nurse?

A I do not have any ER experience.

Q Okay. Then I won't ask that question.

Does the hospital have any policy that prohibits ground transportation crew, such as Elko County EMS or critical care transport crews like REACH, from assisting in patient care in the emergency department?

A No, not to my knowledge.

Q In fact, wouldn't you agree it's common that -- that crew members from either EMS or critical care transport provide patient care under the direction of the hospital in the emergency department?

A Yes.

Q When they do that, when -- when a -- are they doing it under the direction of the hospital -- of the attending?

Page 109

MS. BLAZICH: Objection, calls for speculation, lacks foundation.
MR. DOBBS: I'll object to scope.
Go ahead.
THE WITNESS: Say the question again.
Q (BY MR. BURTON) When EMS or critical care transport teams provide assistance in patient care in the emergency department, is that done under the direction of the attending physician?
MS. BLAZICH: Same objections.
MR. DOBBS: Scope.
THE WITNESS: And I would say to my knowledge, it's -- it's situational. I know they have their own policies and protocols. But if there's a doctor there giving them orders, I don't see that that wouldn't potentially occur as well.
Q (BY MR. BURTON) All right. Let's be more specific.
The code sheet that we've reviewed, was the REACH crew working under the direction of Dr. Garvey when they assisted in this code?
MS. BLAZICH: Objection, calls for speculation, lacks foundation.
Q (BY MR. BURTON) Go ahead.
A I would -- I would say, again, I don't have

Page 110

firsthand intimate knowledge of that. I don't know if that would fall under protocols they have, cause I know they can intubate without a doctor being there.
Q I'll -- I'll be -- I'll be more specific in my question.
In this code sheet, Dr. Garvey was the attending physician, correct?
A That is correct.
Q And there were nurses that assisted in this code under the direction of Dr. Garvey, correct?
A Correct.
Q Because he's the attending, he's calling the shots, correct?
A I would say yes, that is correct.
Q And it looks like there was a respiratory therapist that was there as well; do you see that on the code sheet?
A Yes.
Q And that respiratory therapist works under the direction of Dr. Garvey during the code, correct?
A That's correct.
Q Do you have any -- are you aware of any hospital policy/procedure that says that the REACH crew would be any different from the nurses or the respiratory therapist in that they were not working under the direction of

Page 111

Dr. Garvey?
MS. BLAZICH: Objection, lacks foundation, calls for speculation, scope.
Q (BY MR. BURTON) Go ahead and answer.
A Say the question again.
Q I asked you earlier if the respiratory therapist and the nurses were working under the umbrella or direction of Dr. Garvey.
Do you recall that?
A Yes.
Q And to -- to add more flavor to it, Dr. Garvey can instruct them what to do during the code, correct?
A Yes.
Q Is the REACH crew any different? Can Dr. Garvey instruct them what to do during the code that occurs in the emergency department at the hospital?
MR. DOBBS: Scope.
MS. BLAZICH: Same objection.
THE WITNESS: I think Dr. Garvey can instruct them to.
As the hospital, we don't know their competencies and other things, but I think Dr. Garvey can instruct them to.
Q (BY MR. BURTON) Okay. And in fact, are -- you're aware that many times EMS crews or flight transport

Page 112

crews come in, and the physician has them assist in medical care.
You already testified to that, correct?
A That's correct.
MS. BLAZICH: Same objections.
Q (BY MR. BURTON) And when they do that, they're doing that because the attending gives them instructions, correct?
MS. BLAZICH: Same objections.
MR. DOBBS: Foundation, scope.
Go ahead.
Incomplete hypothetical.
THE WITNESS: I -- I would -- I would have to say each case is different on what they're doing, if it's related to the transport versus something like this where they're involved in a code situation.
Q (BY MR. BURTON) Fair enough.
In this case, are you aware of anything that you've seen in reviewing the records that says that Ronnie Lyons and Barry Bartlett were not working under the direction of Dr. Garvey?
A I -- I haven't reviewed anything that said that they were working directly under his direction, but I would say Dr. Garvey was over this code, and they were team members with Dr. Garvey, the attending.

Page 113

Q And who is the leader of that team? Is it Barry Bartlett, Ronnie Lyons, or Dr. Garvey?
A It's Dr. Garvey.
Q And who was the decision-maker of that team, Barry Bartlett, Ronnie Lyons, or Dr. Garvey?
MS. BLAZICH: Objection, form, foundation.
THE WITNESS: I would say Dr. Garvey.
Q (BY MR. BURTON) And whose decision was it to intubate, Ronnie Lyons, Barry Bartlett, or Dr. Garvey?
MR. DOBBS: Foundation.
THE WITNESS: I -- I would have to say, based on the things that I reviewed, Dr. Garvey decided to intubate.
Q (BY MR. BURTON) And whose decision was it to -- to push rocuronium and ketamine, Dr. Garvey's or somebody else's?
MS. BLAZICH: Objection, form, foundation, speculation.
MR. DOBBS: Scope.
THE WITNESS: And that I -- I can't specifically say that I read or reviewed anything that said Dr. Garvey said to give those. I did read something that said Dr. Garvey said to intubate.
Q (BY MR. BURTON) In your experience, is it common for someone other than the physician to say we're going to

Page 114

push these drugs?
A A CRNA or a provider of another type; but no, not -- nobody other than that in the hospital setting.
Q All right. And in this case there was not a CRNA, correct?
A That's correct.
Q And there was no anesthesiologist, correct?
A Correct.
Q Would the hospital allow -- in the context of this code, would the hospital allow the REACH attendants to provide care to Mr. Schwartz without the authorization of the physician?
MR. DOBBS: Incomplete hypothetical.
THE WITNESS: I guess that question concerns -- doesn't concern me -- but confuses me, because when they do come for a transfer, they do start doing things that are their own protocols that aren't being directed by our physicians, but they're still technically geographically here in our hospital.
Q (BY MR. BURTON) All right. Tell me specifically then what did the REACH employees do here that was their protocol or their procedure versus hospital protocol or procedure.
MS. BLAZICH: Objection, form, foundation, speculation, scope.

Page 115

MR. DOBBS: Join.
Q (BY MR. BURTON) Go ahead and answer.
A I -- I can't say because I don't know their procedures or policies or protocols.
Q All right. Fair enough.
Identify then, if you can, any aspect of the care provided by the REACH employees that was outside of the scope or for -- or procedure dictated by the hospital.
MS. BLAZICH: Same objections.
Q (BY MR. BURTON) Not outside -- sorry -- different than the -- than the procedures of the hospital.
MS. BLAZICH: Same objections.
MR. DOBBS: Form and scope.
Q (BY MR. BURTON) Go ahead.
A The question is did they perform anything that would be outside the scope for our normal employees as well?
Q Yes.
A Not out of their scope of practice to their licensure.
Q No. I'm asking about hospital policy and protocol.
Did REACH come in and do something from a care perspective that was at odds with hospital policy or protocol for the care they provided?

Page 116

A No, because we don't have a policy or protocol for that.
Q All right. Did REACH -- did the REACH crew come in as part of this code event and do anything that the hospital considers to be outside of their scope for a flight paramedic and a flight nurse?
A I -- I can't answer that. I'm -- I do not know the scope of a flight paramedic or a flight nurse. I've never worked in such.
Q And the hospital's never raised concerns that -- that either one of them practiced outside of their area, correct?
MR. DOBBS: Scope.
MS. MONTET: Join.
THE WITNESS: Not to -- not to my knowledge. I don't know if those have ever been arisen that I don't -- I'm not a part of.
Q (BY MR. BURTON) Does the hospital let anybody come off the street and provide care to patients?
A No.
Q I mean if I walked in -- and I used to be a -- an EMT. If I walked in and wanted to provide care to a patient, I would never be allowed to do that, correct?
A That's correct.
Q So why then were the REACH crew allowed to

Page 117

provide care during this code event and the -- and the intubation attempt to Doc- -- to Mr. Schwartz?
MR. DOBBS: Scope, asked and answered.
Q (BY MR. BURTON) Go ahead.
A My understanding is because they were called to transport the patient, which then means they would now be the next care providers, so --
Q Who --
A -- they were now involved in the care. They were -- they were contacted to be involved in the care.
Q Contacted -- who initiated that contact, do you know?
A Our providers initiated transfer.
Q Dr. Garvey?
A Dr. Garvey would have been, yes.
Q You were asked questions about consent, and one of the topics that's at issue for -- that you've been designated as is verbal consents that are required to treat Mr. Schwartz.
Is it hospital policy that every individual provider obtain informed consent or just the physician?
A Say that question again.
Q Is it hospital policy that each individual provider, nurse, respiratory therapist, phlebotomy, all of those individuals also obtain informed consent, or do they

Page 118

operate under the informed consent obtained by the physician?
MS. BLAZICH: Objection, mis- -- misstates the prior testimony.
Q (BY MR. BURTON) I'm not quoting any testimony. I'm just asking you a question.
A The -- the general informed consent is our consent to treat.
Q The general informed consent obtained by the physician.
A Correct.
Q And is it the hospital's position that any that -- any provider that then provides care to the patient in the emergency department is covered by the consent obtained by the physician?
MR. DOBBS: Form.
THE WITNESS: I guess I'm confused by the question.
I mean the doctor -- the doctor gets formal informed consent where they've been given risks and benefits. But every time a provider of any clinician goes in a room, they would say I'm going to do this, and they have their permission. They don't put them down to do it when they don't want them to unless there's some very extreme legal situation.

Page 119

THE REPORTER: Hold on. You cut out. You cut out. I need you to repeat the last sentence.
THE WITNESS: I don't know if I can repeat it verbatim.
MR. DOBBS: Are you -- just maybe to clarify, James, are you talking about a specific procedure that -- as to whether it would be the doctor or everybody involved?
MR. BURTON: Yeah. Let me -- I'll be more specific, and I...
Q When Dr. Garvey received informed consent to do the intubation, that covered the entire team that was working on the intubation attempt, correct?
MS. BLAZICH: Objection, form, foundation, calls for speculation.
Q (BY MR. BURTON) Go ahead.
A That's correct.
Q Meaning if -- if a -- if a nurse then comes in after informed consent is obtained, the nurse doesn't have to say hey, I'm a new nurse, I wasn't in the room when Dr. Garvey got consent, but do you also consent to me doing that. A nurse doesn't need to do that, correct?
A No.
MR. DOBBS: Is that correct?
Q (BY MR. BURTON) That's correct?

Page 120

A Oh, I'm sorry. That is correct.
Q Okay. During the code event, did you review -- are you aware of any policy or procedure of the hospital that says anybody but Dr. Garvey is the final decision-maker?
A No.
Q During -- based on what you've reviewed, are you aware of any policy or procedure of the hospital that says that the REACH crew could come into the emergency department and tell Dr. Garvey how to run the code event or how to run the intubation attempt?
A No. I would not say that there's any policy that says that they can tell a doctor. They can give recommendations, as all clinicians do, to doctors, but they would then make the final decision.
Q And a nurse could give a recommendation as well, correct?
A Correct.
Q And an RT could give a recommendation, correct?
A Correct.
Q And the -- the flight transport crew could also give a recommendation, correct?
A Correct.
Q But ultimately it's on the physician to decide how best to carry out whatever procedure he's doing.

Page 121

A That's correct.
Q Sorry. I'm just going through my notes. My notes are a little jumbled.
Based on your review of the records and your -- and your understanding of the intubation attempt and the code response, was there anything that you saw that said that Mr. Schwartz was given rocuronium or ketamine by anybody without his consent?
MS. BLAZICH: Objection, form, foundation.
THE WITNESS: No.
Q (BY MR. BURTON) Based on your review of the records and your familiar- -- familiarity with hospital policy, are you aware of any evidence that suggests that Mr. Schwartz was -- that intubation attempts were attempted on Mr. Schwartz without his consent?
MS. BLAZICH: Same objection.
THE WITNESS: No.
Q (BY MR. BURTON) When I say that, I'm talking with respect to whether nurses, RTs, flight crew, Dr. Garvey, any indication that any of those did not have consent to attempt intubation?
MS. BLAZICH: Same objection.
THE WITNESS: No.
Q (BY MR. BURTON) Based on your review of the records and your understanding of hospital policy, did the

Page 122

REACH crew assault Mr. Schwartz when they provided medical care to him?
MS. BLAZICH: Objection, lacks foundation, calls for speculation.
MR. DOBBS: Scope.
Go ahead.
THE WITNESS: No.
Q (BY MR. BURTON) Based on your review of the records and your understanding of hospital policy, did the REACH crew falsely imprison Mr. Schwartz when they provided medical care to him as part of the intubation attempts and the -- the code response?
MS. BLAZICH: Objection, lacks foundation, calls for speculation, scope, and asked and answered.
Q (BY MR. BURTON) Go ahead and answer.
A No.
MR. BURTON: All right. I think I'm done. Give me just two seconds.
MR. DOBBS: If you want to look over, James, I'm going to ask a few questions in follow-up too.
MR. BURTON: Yeah.
MR. DOBBS: Is that okay?
MR. BURTON: Yeah. Give me just one second. I thought there was one more that I wanted to ask.
Yeah, go ahead, Tyson. And then -- and then if I

Page 123

have more questions, I'll just jump on the back end.
And if I don't, Ms. Jones, thank you for your time. I appreciate it.
THE WITNESS: Thank you.
EXAMINATION
BY MR. DOBBS:
Q All right. Ms. Jones, if you could explain for me just briefly the configuration of rooms 11 and 12 in the ER for me.
A So it's a larger room, but it's one big room with a curtain that divides the two.
Q And it's -- is there -- as far as the crash cart, explain for me -- I think you testified earlier that there's one crash cart between the two rooms?
A Correct.
Q Okay. So it's for either room, if they need access to the crash cart, they're going to use the same one.
A That's correct.
Q And as far as the trauma carts, there's also a trauma cart in each room.
A That's correct.
Q Could you provide an estimate about how many steps away from the -- from the bed in room 11 the bed in room 12 would be, or how many feet, do you have an

Page 124

estimate?
A I would say seven or eight feet.
Q So they're pretty close?
A They're pretty close.
Q We discussed it earlier that you reviewed several portions of deposition transcripts in this case.
A That's correct.
Q Okay. And -- and so you -- did you review the deposition of Dr. Garvey as it relates to equipment that his -- the testimony he gave regarding the equipment needed for intubation?
A Yes.
Q Did you review the deposition testimony regarding equipment needed for deposition [sic], testimony that was given by Barry Bartlett, do you remember?
A I don't -- I don't remember Barry --
Q Okay.
A -- Bartlett's.
Q But Dr. Garvey you did.
And then Tom Evers, did you re- -- review deposition testimony from Tom Evers about the equipment needed for the deposition -- or --
A Yes.
Q -- for the intubation?
A Yes.

Page 125

Q And then you reviewed the deposition regarding -- of Donna Kevitt regarding the equipment that was available at the time of the intubation as well?
A Yes.
Q Did Dr. Garvey -- as far as your review of the records, was there any indication in his testimony that you reviewed regarding the equipment, that there was any missing equipment for the intubation?
A No.
Q And same question goes for Tom Evers, in the review of Tom Evers' deposition, did you see anything that indicated to you that there was equipment needed but was unavailable for the intubation?
A No.
Q In Donna Kevitt's testimony, she was asked in her deposition about the equipment that she had to gather, correct?
A Correct.
Q And what was her -- as far as your recollection, what was her response as to what equipment she had to run and get from somewhere else in the -- in the ER?
A I remember that she said she had to get a -- a Bougie from the wall and use two suction devices.
Q Okay. And -- and she says a Bougie from the wall. What is -- why is there a Bougie on the wall? Do

Page 126

you -- I mean --
A They have them taped on the wall so they can just easily grab them and use them.
Q And where in the room are they taped?
A Right at the head of the bed area.
Q And we've -- we've -- we reviewed earlier the trauma cart inventory list, and I believe we saw in there there's -- there's Bougies in those trauma cart inventory lists as well.
A Correct.
Q But in addition to the Bougies being in the trauma carts, they're also taped up on the wall?
A That's correct.
Q And from the review of -- of Donna Kevitt's deposition, the only thing that -- the equipment that she needed to run somewhere else to get was her testimony regarding the Bougie; is that right?
A That's correct.
Q So other than the Bougie, did you see anything in -- in those depositions that you reviewed that indicated that there was any missing equipment for the intubation?
A No.
Q In your -- from your review of the records in this case, in the deposition transcripts that you

Page 127

reviewed, did you determine that the -- the equipment that -- needed for the intubation was indeed available there in the room for Mr. Schwartz's intubation?
A Yes.
Q And the only thing that had to be pulled from a different source other than the trauma cart, or wherever, was Donna Kevitt running out to -- to the top of the bed to grab the Bougie.
A Correct.
Q Do you -- do you know if this case was reported to the coroner the day after the incident? Do you know that? Or do you recall?
A I don't -- I don't know that. That would be customary, but I --
Q If --
A -- don't know that that...
Q If -- if there -- if this was indeed a case in which there had to be information sent to the coroner's office, that would require the -- the nursing staff or the -- the clerks present to indeed pull the records, print those, and -- and get those ready for the coroner; true?
A Yes.
Q And I think your testimony earlier about the -- I just wanted -- just wanted to clarify this.

Page 128

As far as occurrence reports, the policy is that any person involved in an incident has an obligation to prepare an inci- -- incident report; is that correct?
A Yeah. Anybody -- any -- the intent of that is if anybody is aware of an event, you have an obligation to report it.
Q Now -- but is -- is -- is it the hospital practice or policy that every person involved in the event has to prepare an incident report, or is it just one incident report per incident?
A It's one incident report per incident.
Q So the expectation of the hospital is that somebody involved in that incident is going to prepare an incident report.
A That's correct.
Q So the fact that there's only one incident report regarding this -- or when I say incident report, I'm -- I'm using that chan- -- term interchangeably with occurrence report, the fact that there's only one occurrence report in this case, it doesn't surprise you. That seems customary.
A That's correct.
MR. DOBBS: That's -- that's all the questions I have.
MR. BURTON: Shirley, do you have any follow-up?

Page 129

MS. BLAZICH: Just maybe two or three questions. Do you -- James, do you want to finish yours or...

MR. BURTON: I'm -- I'm happy to go first so that you can kind of have the -- the last word.

FURTHER EXAMINATION

BY MR. BURTON:

Q Mine will be very brief, Ms. Jones. Are you familiar with the concept of medical control?

A No.

Q Do you -- so if I ask you who had medical control of the patient, you don't -- you don't understand what that means?

A I've never --

MS. MONTET: Object to form.

THE WITNESS: I've never heard that term before.

Q (BY MR. BURTON) Okay. Who was the final -- I asked you earlier who the final decision-maker was for patient care, and you testified it was Dr. Garvey, correct?

A Correct.

MS. MONTET: Objection, lacks foundation, calls for speculation.

Q (BY MR. BURTON) As part of the care provided to

Page 130

Mr. Schwartz, would it have been Dr. Garvey who determined who participated in the medical care?

MS. MONTET: Same objections.

Q (BY MR. DOBBS) Go ahead.

A I -- I would say Dr. Garvey consults or, like I said in this situation, contacted a flight team that would then participate in the care of the patient.

Q Yeah. And let me -- let me frame it from the opposite perspective. If Dr. Garvey did not want somebody to participate in patient care, he certainly had the ability to say no, I don't want you to participate, correct?

MS. MONTET: Objection, form, lacks foundation.

THE WITNESS: I -- I would say that if any clinician saw something or was involved in something that they were concerned about, they would try to stop it.

Q (BY MR. BURTON) No. And I -- my question was probably --

A Sorry.

Q -- poorly worded. What I mean is if Dr. Garvey would have not wanted the REACH crew to assist, it was well within his authority to tell them not to assist, correct?

MS. MONTET: Same objections.

THE WITNESS: Correct.

Page 131

Q (BY MR. BURTON) Go ahead. What was your answer?

A I would say that is correct.

Q And the hospital would not allow care to be provided by REACH if the hospital thought that care would be illegal, correct?

MR. DOBBS: I'm sorry. Could you repeat the question?

MR. BURTON: Yeah.

MR. DOBBS: Sorry. I missed it.

MR. BURTON: You're good.

Q The hospital would not allow the REACH crew to provide care to Mr. Schwartz if the hospital had concerns that that care would be illegal, correct?

MS. BLAZICH: Objection, form, foundation, calls for speculation.

MS. MONTET: Join.

MR. DOBBS: Scope.

MS. MONTET: Join in that as well.

THE WITNESS: I would say that that's correct, but I don't know how the hospital would be involved in that, I guess.

Q (BY MR. BURTON) Well, if the hospital was concerned that the assistance of REACH were either illegal or unlawful, the hospital would not -- would not allow that care to be provided; is that fair to say?

Page 132

A If --

MR. DOBBS: Scope.

THE WITNESS: I would say if you're saying, by the hospital, by any representative of who works here, because the hospital's an entity, so they're not there while it's happening to know.

But if an employee of the hospital saw there was something that they thought was inappropriate, yeah, we would want them to -- I guess to query the physician on that, on their concern.

Q (BY MR. BURTON) And then ultimately it would be the physician's determination to exclude somebody from providing care, correct?

A Well --

MR. DOBBS: Scope.

THE WITNESS: -- I -- I think that's a hard --

MS. MONTET: Join.

THE WITNESS: -- question to ask. So if he said I don't want the respiratory therapist involved in care, but we only have one respiratory therapist, I don't know where that would lead us.

Q (BY MR. BURTON) In that scenario --

A Do you get what I'm saying?

Q I do.

Page 133

In that scenario, who would then overrule the physician and say no, the respiratory therapist is going to participate in the care?
MR. DOBBS: Incomplete hypothetical.
THE WITNESS: I -- I would say that there's nobody that's going to necessarily overrule the physician at the time. He's just going to not have something available to him potentially.
MR. BURTON: All right. Thank you.
That's all the questions I have.
MS. MONTET: This is Jordan Montet for Ruby Crest. I just have a couple questions, if you want me to go before you do, Shirley.
MS. BLAZICH: Yeah, go ahead, Jordan.
EXAMINATION
BY MS. MONTET:
Q Okay. I just have a couple quick questions for you.
When we were speaking earlier about the transport providers, are -- are those transport providers, to the best of your knowledge and your experience -- are they medical clinicians in their own right, with the ability to exercise their own medical judgment?
A Yes.
Q And they have -- they are medical clinicians who

Page 134

are there to advocate for the patient as well?
A Yes.
Q So if they disagreed with a decision, would it be -- would it be their obligation as medical providers to speak up as to that disagreement?
A Yes. Like I said, everybody can make a recommendation by what they're seeing to the provider.
Q Have you reviewed the -- or do you know what the credentials are or were for the medical providers at REACH Air who were involved in Mr. Schwartz's care?
A No. All I can go off is what it -- it tags behind their name in the charting, like Barry R.N.
Q Do you know if either of those medical providers were able to prescribe any medications?
MR. DOBBS: Scope.
THE WITNESS: So I -- I know the scope of the nurse, and we don't prescribe medications. But, like I said before, I don't know their protocols or policies on when they can implement a protocol.
Q (BY MS. MONTET) Okay. And just to follow up to that, do you know in a transport --
A Sorry. I think we're losing you. I can't -- I'm getting every other word.
Q Oh, I'm sorry. I'll repeat that.
Do you know that if -- in the context of a

Page 135

transport, if the REACH policies are in place concurrently with the hospital or if they take precedent over the hospital policy?
MR. BURTON: Objection, speculation.
MR. DOBBS: Scope.
MR. BURTON: Foundation.
THE WITNESS: We have no --
MR. DOBBS: Foundation.
THE WITNESS: We have no policy that states that one way or another.
MS. MONTET: Okay. Thank you.
That's all I have.
FURTHER EXAMINATION
BY MS. BLAZICH:
Q All right, Ms. Jones. I'm going to try to be really brief. I'm -- I'm sure you're sick of me by now.
Let me -- let me just go back to something that you said when Mr. Dobbs was questioning you.
You indicated that all -- you testified that all the equipment in the trauma cart was available for the care and treatment of Douglas Schwartz.
Was that your testimony earlier?
A What I said is what I reviewed, nobody that was present said there was anything missing. I don't know personally firsthand knowledge.

Page 136

Q That's what I wanted to clarify.
You don't have any personal knowledge either way of whether or not there was anything missing from the trauma cart, correct?
A No.
MR. DOBBS: Foundation. I mean she's a PMK, so I guess of course she's not going to have firsthand knowledge, but...
THE WITNESS: Based -- based on my review of other people's depositions, I would think that they would know if there were things missing from it.
Q (BY MS. BLAZICH) Okay. And so that understanding is coming entirely from the depositions that you've reviewed in this case, correct?
A That's correct.
Q You have not made any effort to contact any of the people who were involved in the code for Mr. Schwartz to ask them about equipment availability in the trauma cart, correct?
A That is correct.
MS. BLAZICH: I don't have any other questions.
FURTHER EXAMINATION
BY MR. DOBBS:
Q I -- I got one more question.
And from your review of Donna Kevitt's

deposition, was she asked about what equipment was available?

A I believe she was.

Q And what did she say as far as what equipment was not available?

A She said nothing that she could think of really, but she did remember having to go get the Bougie from the wall.

MR. DOBBS: That's all I have.

MS. BLAZICH: Anyone else?

MR. BURTON: Thank you, Ms. Jones.

THE WITNESS: Thank you.

MS. BLAZICH: It's always fun to be the last one of the day.

MR. DOBBS: We'll read and sign.

MR. BURTON: Everybody have a great weekend.

MS. BLAZICH: Thank you.

MS. MONTET: Thank you.

MS. ULREY: This concludes -- this concludes the deposition.

The time is 5:25 p.m., and we are off the video record.

(The taking of the deposition was adjourned at 5:25 p.m.)

* * * * *

CERTIFICATE OF DEPONENT

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I, RABECCA JONES, R.N., deponent herein, do hereby certify and declare under penalty of perjury the within and foregoing transcription to be my testimony in said action, that I have read, corrected, and do hereby affix my signature to said transcript this _____ day of _____, 20_____.

_____

RABECCA JONES, R.N.

Deponent

CERTIFICATE OF REPORTER

STATE OF NEVADA)

ss:

COUNTY OF CLARK)

I, Lori M. Unruh, a Certified Court Reporter licensed by the State of Nevada, do hereby certify:

That I reported the taking of the deposition of the witness, RABECCA JONES, R.N., commencing on Friday, December 4, 2020, at 2:04 p.m. Pacific Standard Time. That prior to being examined the witness was by me duly sworn to testify to the truth. That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true and accurate transcription of said shorthand notes.

I further certify (1) that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action, and (2) that transcript review by the witness pursuant to NRCP 30(e) was requested.

IN WITNESS WHEREOF, I have hereunto set my hand in my office in the County of Clark, State of Nevada, this 14th day of December 2020.

Lori M. Unruh, RDR, CCR No. 389

Deposition of
RABECCA JONES, VOLUME II

SCHWARTZ v. GARVEY, et al.

Case No. CV-C-17-439

August 19, 2021

CONDENSED TRANSCRIPT AND KEY WORD INDEX

TURNER REPORTING & CAPTIONING SERVICES, INC.
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IN THE FOURTH JUDICIAL DISTRICT COURT OF THE
STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

DIANE SCHWARTZ, individual and as Special Administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased,
Plaintiff,
vs.
DAVID GARVEY, M.D., an individual; BARRY BARTLETT, an individual (Formerly Identified as BARRY RN); CRUM,) STEFANKO & JONES LTD., dba Ruby Crest Emergency Medicine;) PHC-ELKO INC. dba NORTHEASTERN) NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business) in the State of Nevada; REACH AIR MEDICAL SERVICES, L.L.C.; et al.,
Defendants.

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

VIDEO-RECORDED DEPOSITION OF
RABECCA JONES, VOLUME II,
AS 30(b)(6) DESIGNEE FOR PHC-ELKO, INC.
d/b/a NORTHEASTERN REGIONAL HOSPITAL
Taken on Thursday, August 19, 2021
At 10:04 a.m.
(All attendees appearing by videoconference)

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

Page 141

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Also Present: BECKY ULREY,
CERTIFIED LEGAL VIDEOGRAPHY

Page 142

EXAMINATION

EXHIBITS
(None marked)

Page 143

THE VIDEOGRAPHER: Good morning. This begins the 30(b)(6) video-recorded deposition of Rabecca Jones, Volume II, taken on August 19, 2021, at the time of 10:04 a.m. This matter is entitled Diane Schwartz, et al., versus David Garvey, M.D., et al., Case No. CV-C-17-439 in the Fourth Judicial District Court of the State of Nevada in and for the County of Elko.

My name is Becky Ulrey with Certified Legal Videography. The court reporter is Vicki Turner with Turner Reporting Services.

Will all attorneys participating please stipulate that the court reporter is not physically present with the witness and that she may administer the oath remotely. If in agreement, please state your name and consent for the record.

MS. BLAZICH: Good morning. Shirley Blazich on behalf of the plaintiff, and I consent that the court reporter is located remotely from the witness.

MR. DE JONG: Richard De Jong for NNRH and the deponent. We also consent.

MS. HUETH: Chelsea Hueth for Ruby Crest Emergency Medicine, and I consent.

MS. BESTICK: Alissa Bestick for Dr. Garvey, and I consent.

MR. WESTERBERG: Austin Westerberg for REACH Air,

Page 144

and I consent.
THE VIDEOGRAPHER: Thank you.
The reporter will now administer the oath.
RABECCA JONES
was called as a witness by the Plaintiff and, having been first duly sworn, testified as follows:
EXAMINATION
BY MS. BLAZICH:
Q Ms. Jones, would you mind stating your full name and spelling it for the record.
A Rabecca Jones. R-a-b-e-c-c-a, Jones, J-o-n-e-s.
Q Thank you.
Ms. Jones, normally I would ask you if you've had your deposition taken before, but I've taken your deposition before; correct?
A Yes.
Q Would you like me to go over the rules for a deposition one more time for you, or do you feel pretty comfortable that you know them from the last deposition?
A No. I think I understand them.
Q Okay. All right. Perfect. Thank you.
So, Ms. Jones, it's my understanding that you are testifying here today on behalf of the

Page 145

hospital, that being Northeastern Nevada Regional Hospital; correct?
A Yes.
Q All right. And very quickly, I'm going to pull up a copy of the deposition notice just to go over the topics that I believe that you will be testifying on. So bear with me for just a second here.
All right. So what I have pulled up is Plaintiff's Notice of Taking the Continued Videotaped Deposition of Defendant PHC-Elko, Inc., dba Northeastern Nevada Regional Hospital's NRCP 30(b)(6) Witness(es). And the time and date for the deposition is the 19th day of August at 10:00 a.m., which is now.
And then I wanted to show you what is attached as Exhibit A, which is a list of 40 topics that were part of the original list of topics.
So my question, Ms. Jones, have you had an opportunity to review this deposition notice and specifically Exhibit A?
A Yes.
Q Okay. And it's my understanding today that you are going to be testifying as through -- as for Topics 1 through 10 on Exhibit A; is that accurate?
A Yes.

Page 146

Q All right. And then you're also going to be testifying as to Topic 31 on the page in front of you.
A Yes.
Q And you're going to be testifying as to Topic No. 38; is that correct?
A Correct.
Q Okay. And is it your understanding that that's all the topics that you will be testifying to today?
A Yes.
Q All right. And have you agreed to testify on behalf of Northeastern Nevada Regional Hospital?
A Yes.
Q And do you understand that your testimony will be binding upon the hospital today?
A Yes.
MR. DE JONG: I'm just going to object to the -- the form of that question.
Q (BY MS. BLAZICH) Okay. Let me reask it.
Do you understand that as the corporate designee, your testimony will be that of Northeastern Nevada Regional Hospital in this case?
A Yes.
Q Okay. Great.
Would you mind telling me what documents, if

Page 147

any, you reviewed in preparation for your deposition today.
MR. DE JONG: If you can remember.
THE WITNESS: I remember reviewing some education and orientation files, the mission and vision values policy. That was most of the documents I saw, was around orientation and different trainings that we would have done.
Q (BY MS. BLAZICH) Okay. And that was specifically for the employees that were listed in Items 1 through 10 of the deposition notice; correct?
A Correct.
Q Okay. Is there anything else that you reviewed other than what you already told me about?
MR. DE JONG: Again, to the extent you can recall everything that you reviewed.
THE WITNESS: There was files -- there was training and credentialing for Dr. Garvey as well.
Q (BY MS. BLAZICH) Oh. Okay. Did you review your deposition transcript from the prior deposition that you gave in this case?
A I did see that. I did peruse that, yes.
Q What about any other depositions that you would have reviewed specifically in preparation for today?

Page 148

A I don't recall reviewing any other depositions.
Q Okay. Other than speaking to your attorney, did you speak to any other staff or employees at Northeastern Nevada Regional Hospital in preparation for your deposition today?
A No.
Q All right. And then remind me, Ms. Jones, what is your position with Northeastern Nevada Regional Hospital at this time?
A At this time, it's ACNO, Associate Chief Nursing Officer.
Q As the Associate Chief Nursing Officer, are you also a registered nurse?
A I am.
Q How long have you been the Associate Chief Nursing Officer?
A Three months.
Q What was your title the last time I took your deposition? I can't recall what it was.
A Director of Cardiopulmonary Services.
Q All right. In your new position as the Associate Chief Nursing Officer, what are your primary duties and responsibilities?
A Oversight on specific clinical areas and

Page 149

departments of the hospital and to assist the Chief Nursing Officer in that oversight.
Q So is the Chief Nursing Officer your direct supervisor?
A Yes.
Q When you say oversight of clinical areas of the hospital, does that include the emergency department?
A No. I do not currently have the emergency department.
Q Is there also another Associate Chief Nursing Officer?
A No.
Q You are -- you are the only person who holds that position?
A Yes.
Q Do you know who has oversight over the emergency department?
A The director, and then she reports to the Chief Nursing Officer.
Q All right. So is there a director of nursing?
A No.
Q Just the hospital --
A Director -- director of the emergency

Page 150

department has oversight, and then she reports up to the Chief Nursing Officer.
Q And who is the director of the emergency department?
A Jennifer Tingle.
Q In your current position as Associate Chief Nursing Officer, are you in any way responsible for employee hiring?
A Just the direct hiring of people that are being hired into my direct departments that I oversee.
Q What departments do you oversee?
A Cath lab, cardiac and pulmonary rehab, respiratory therapy, house supervision, and the sleep center.
Q So if a new employee is being hired into one of those departments, how are you involved in that process?
A I interview into those departments, outside of the sleep center, which is a contracted service. So those employees are not employed by us.
Q Anything else that you do besides interview?
A I interview and I offer the -- I offer hiring.
Q How do you pick which individuals to interview? Like, who goes through applications or

Page 151

resumes and selects the people to be interviewed?
A So they go through a -- an online application process. And if they meet minimum requirements, those applications come to me for review, and then I contact them to interview them.
Q So you would pick out of the individuals who applied online and met minimum requirements.
A That's correct.
Q Just so I sort of have an understanding, can you, to the best of your ability, walk me through the process of when you are hiring an employee for one of the departments that you oversee, how does that process work step by step? You've already told me that people would apply online, and if they meet minimum requirements, then their application would come to you for review, and then you would select individuals to interview.
So from that point on, once you've selected individuals to interview, what are the next steps before you make an offer?
A So we contact to schedule an interview. If they have completed their assessment -- so there is an assessment tool that they complete online as well. And the results of those questions generate an interview tool guide for us. A focus behavior

Page 152

assessment basically is what it's called. And then we contact them, schedule a meeting, and we do peer interviews. So I lead the interview, but I pull in staff members of the area they're applying to. And we conduct the interview with me leading it with some peers.

And then after we've completed an interview process, we either bring them for an on-site shadow opportunity, if they are new to our facility or our area. And then that might generate a second interview potentially, or, if not, if we're -- if we're solid that the candidate is a good fit for us and we're a good fit for them, then we would offer the job.

Q Okay. And then prior to an employee -- or a potential employee receiving a job offer, is there any type of background check or license verification that is done by the hospital?

A Before being offered a job? No.

Q Oh, okay.

What happens, then, after they've been offered a job?

A So if an employee is offered a position and they have accepted, then we would run the processing of onboarding that person, getting all of their credentials, putting out for a background check, all

Page 153

the hiring requirements.

Q All right. Would you walk me through what those onboarding procedures are once an employee has received a -- or a potential employee has received a job offer and they've accepted it.

A I -- I can't tell you exactly since I don't work in the HR department. So I don't know if I would miss details 'cause the HR department is who meets with the employee and fills out forms and, you know, actually sends out for a background check and those things. So I don't know intimately every detail that happens in that process.

Q Fair enough.

Do you know, are all potential employees subjected to a background check before starting work?

A Yes.

Q And are all potential employees subjected to verification of whatever professional licenses they hold prior to starting work?

A Yes.

Q Is there anything else that generally you're aware of in terms of sort of vetting potential employees before they start work?

A I know there's processes with employee health, getting vaccination records, TB testing, other

Page 154

elements like that. We sign security agreements so we can get them access to our systems. That all happens in that process at some point.

Q And then when a new employee joins the hospital in -- for example, in the departments that you oversee, do they go through some type of probationary period? Orientation training? How does that work?

A Yes. So all employees, depending on the department they go to, have a designated amount of time to orient. And there's -- we have a 90-day probation here at our facility. And there's a 30-day and a 60-day and a 90-day check-in with that employee to review their orientation, questions, fit. Just -- it's a retention strategy, you know, that we do with our employees to see if the process is going well for them and also going well for us with our expectations. And the orientation, though, is very specific to the department on length of time and what they -- what they do during it.

Q Okay. So they all do some form of orientation and check-ins and probation. It just varies with the department and the position.

A That is correct.

Q Okay. One other thing I wanted to ask you

Page 155

about the onboarding process.

Is there -- is part of that process involving checking references for the potential employee?

A I can't really speak to that. I don't know -- I have no involvement in that part of it.

Q All right. All right. So after an employee is hired and goes through orientation and their probationary period and their periodic check-ins, do they then at some point have the probationary status lifted?

A Well, I -- there's no action. It's just -- it's 90 days from hire is their probationary period unless otherwise indicated it will be extended for some reason. Otherwise, it's for 90 days for employees.

Q And do you know, what types of things is the hospital looking at during a 90-day probationary period? What types of behaviors from the employee or what type of work performance? If you know.

A Sure. I mean, there's any number of things. How well they are adapting to the environment, the team, their skills, their learning curve. We're assessing some -- you know, adult learners learn in many different ways, and some we have to extend the

Page 156

orientation time and some we can shorten based on their experience and their learning style and method. That's why we meet with them regularly to see how they're doing.

We have a lot of questions where we talk to them if we are living up to what we said in the interview process and what they expected for the job that they came to as well as if we have any of our expectations that aren't being met or if -- or what ones they are doing a good job of at that time so they know kind of where they stand and where both of us need to work on.

Q So if they need some additional training or additional guidance, would you expect that that would be revealed during that probationary period?

A To the extent that those situations arise, I would say in our profession, you can spend 90 days on -- in a probation status and orientation for any given weeks, but maybe you don't experience something on that designated amount of time. And we don't keep you on orientation. So yes, the things that they have experienced or exposure to and opportunities for we would assess at that time. And if there was gaps, we would readdress.

Q Okay. So anything -- any issues that arise

Page 157

during the probationary period could potentially lead to that employee receiving additional training.

A Potentially, yes.

Q And then once an employee has cleared that probationary period, is there sort of a periodic review process that hospital employees go through?

A Yes. Annually we review and evaluate employees' performance.

Q And is that done for all employees?

A That is done for all employees. And nursing and clinical staff also have an additional skills day review that we also participate in annually.

Q So there's a skills day review for clinical staff.

A That's correct.

Q And does that include, you know, taking like little tests or quizes to just assess their ongoing knowledge and education level?

A Not just tests or quizes, but hands-on actual demonstration of certain elements.

Q Okay. So both. They might take a written test and have a hands-on clinical assessment.

A Yes. That is correct.

Q All right. Perfect. Thank you for walking me through that.

Page 158

Is there anything else as part of that hiring and onboarding process that I -- I may have missed that you're aware of? Any additional steps in that process?

A Not that are coming to mind right now, no.

Q All right. So when a potential employee submits an online application, do you know, do they simply fill out their work history online or can they upload a resume or CV?

A They can do both. They can fill out the work experience online, and they can also have an opportunity to upload their own resume.

Q And forgive me, I don't have a copy of what a typical application would like look.

Do you know about sort of the typical questions that a hospital employment application would ask?

A I know generally. I don't know all-inclusive.

Q Fair enough.

Generally, what types of information is the hospital asking a potential applicant for in a application?

A What job they're applying for, their contact information, their work experience, their education

Page 159

history, their skills and abilities. That's all I can think of right now when I'm thinking of the screens. And then I also mentioned that assessment screening tool that they complete as well.

Q I'm assuming a -- a work application would have an area for your educational history; correct?

A Yeah. I think I listed that.

Q Okay. And probably a place to provide professional references; correct?

A I -- I have not seen that part of it on the application because we don't contact the references or anything. So -- but I imagine that is there. It's pretty typical.

Q So what -- what -- what is the purpose of having potential employees go through the application process?

A I don't know. Maybe -- I don't understand your question.

Q Sure.

When the hospital is looking to hire staff, why do they request that they submit an online application and meet minimum requirements?

A I think for any job, you have to be able to have a avenue or a tool to apply for it. And any job has minimum requirements.

Page 160

Q Is the purpose of going through the application process in order to hire the best possible applicants for the job?
MR. DE JONG: Object to form. Foundation.
You can go ahead and answer it to the extent that you can.
THE WITNESS: I think it's any employer's intent to, yes, get applicants -- various applicants so you can look at them and pick the best one for your fit and their fit.
Q (BY MS. BLAZICH) And you want to be sure that those applicants meet your minimum hiring expectations for the -- for that position; correct?
A Yes. I think that that's why everybody has minimum requirements, that you have to be at this level to be qualified for the job.
Q You mentioned that there's an assessment tool that is also done as part of the online process.
Is that -- if it was a clinical position, is that sort of a clinical skills assessment tool that they would be asked to complete?
A No. It is a behavioral assessment. And they are based on the position they're applying for. It asks different questions, but they are behavior assessment questions.

Page 161

Q Okay. And does the -- if you know, is that sort of a program the -- the hospital has purchased and used, or is it something that you all have developed the -- the specific questions to ask during the behavioral assessment tool?
A We do not develop it. It's a program that is purchased and used.
Q Do you know the name of the program?
A I do not. It -- it is through our application process, and there's a link in the application to click to see it. So I don't know the background, who administers that part of the program.
Q But you do believe that's a third party that administers that behavioral assessment tool.
A Yes. I do know we did not create those questions locally.
Q Okay. And then what -- what information would you get prior to a potential interview from the behavioral assessment tool?
A I get a report of the results of those questions, and it gears our interview -- it guides our interview questions. So if they scored low maybe in an area of teamwork based on their answers, it focuses a lot more questions during the interview on teamwork-guided questions.

Page 162

Q And so what would you say is the purpose for having a potential employee complete a behavioral assessment tool prior to hire?
A It gives us an individualized interview plan based on that specific individual.
Q Is it at all designed to ensure that the people working at the hospital meet your standards for work ethic and teamwork?
MR. DE JONG: Object to form and foundation.
THE WITNESS: I think these tools are resources that companies use to try to help get the best candidate. I don't think that there is a guarantee in any industry of that, but it is a tool to try to achieve those goals.
Q (BY MS. BLAZICH) Okay. So it's a goal of the hospital to recruit and hire the best candidate, and the behavioral assessment tool aids in achieving that goal.
A Yes. I believe so.
Q Okay. Who develops the minimum requirements for a particular position?
A It's in the job descriptions, and HR and the director of those areas develop those collaboratively.
Q Do you participate in developing the minimum requirements for positions and departments that you

Page 163

oversee?
A Yes.
Q And can you give me some examples of the types of minimum requirements that you might want included in a job posting for one of the departments that you oversee?
A I can give you an example of a specific position.
Will that help?
Q That would help, yes. Thank you.
A Okay. So if it's a cath lab RN, some of the minimum requirements would be besides an RN license, they would have to have at least a minimum of one year's of critical care experience, and they have to have ACLS and BLS within six months of hire.
Q Okay. Anything else?
A I mean, there's -- they have to be able to lift 50 pounds. And there's all kinds of other ones. But as far as the -- the training and the additional things that an RN license would have to have would be the critical care experience and the ACLS and BLS.
Q And you would expect that applicant to have those minimum requirements before starting work; correct?
A Unless it's stated, like I mentioned, ACLS,

Page 164

BLS within six months of hire.
Q And, again, that -- those minimum requirements are to ensure that the hospital has qualified individuals working at it; correct?
A I will say it does not guarantee it. It is the goal to use that as a resource and an avenue to attempt to achieve that.
Q All right. So the intent is to try to get the best and most qualified applicants to work at the hospital. That's the goal.
A Of course.
Q All right. So when a prospective employee is given on-site shadowing opportunities, how long does something like that typically last?
A That's variable to the department and to if it's a local candidate versus a candidate from outside of our area. It's very -- it's very variable.
Q Okay. So not everybody may need or be available for a shadowing opportunity.
A That is correct.
Q But if the hospital determines that a shadowing opportunity would be a useful tool in determining whether that employee would be a good hire, then that's something that the department can decide to do on an as-needed basis.

Page 165

Would that be fair?
A That's correct. But not just that we think it would be a good hire, but often to give that candidate the opportunity to see what they are really coming to to see if we would also be a good fit for them.
Q And it gives you all a chance to see them in action and --
A No. I would not say "in action" because they are shadowing. They cannot perform or do anything while they're here.
Q All right. It's more a chance for them to ask questions and observe how things work at NNRH.
A Yes.
Q So then you mentioned that there would be a second -- sometimes there would be a second interview; correct?
A If there was -- yes. If there was multiple candidates and they wanted to bring back any of the candidates for a second, yes. Otherwise, no. But again, ad hoc if it was needed.
Q And then are job offers typically given in writing?
A Yes.
Q And is the employee or prospective employee

Page 166

asked to sign off on the job offer and return it as a way to accept the offer?
A Yes.
Q All right. And so, then, once the employee has accepted the job offer, then the onboarding process starts; is that fair?
A Yes.
Q And what is the purpose of the onboarding process?
A To complete all the paperwork and requirements of screenings, further screenings, like the background check and getting documents on their TB testing and those things I mentioned before, to get them all together so that we have them to be able to bring them to our facility for employment.
Q So during the onboarding process, that's when you actually check to make sure that the employee has the licenses that they claim to have; correct?
A Yes.
Q And that you've done a background check to make sure that there's nothing concerning in their background; correct?
A Yes.
Q Also a time that you would perform the employee health screening to make sure that they don't

Page 167

have any communicable diseases that they might be bringing into the hospital.
A No, we don't screen them. We have them provide us their vaccine records. That doesn't guarantee they don't have a communicable disease.
Q Oh, okay. So they provide their vaccine records.
And do they undergo a TB test?
A They can provide us a copy of the TB test if they've already got a current one. Or yes, we give them a TB test if they haven't had one within the required time frame.
Q All right. And, obviously, the hospital would not want people coming and working at the hospital who didn't actually have the licenses that they claim to have; correct? You'd want to --
A Correct.
Q You'd want to check that before you would let the employee start work.
A Correct. We do first source verification for licenses.
Q And what does that mean, "first source verification"?
A Our HR director or designee looks at whoever administers those licenses and looks at their website

Page 168

to verify they have a license.
Q So if it was a nursing license, you would look at the State Board of Nursing.
A That is correct.
Q All right. Perfect.
And then once an employee is hired and working at the hospital, do you know, is there a system of progressive discipline for employees?
A We -- we have a policy called fair accountability where we can, yes -- we can coach and discipline employees.
Q And I don't need to know all the details of that policy. I haven't seen it. But is it something along the lines of there being a verbal warning and then a written warning, and eventually it could lead to suspension or termination?
A Yes.
Q Okay. And when you say that -- the policy is called fair accountability?
A Well, that's the type of discipline we do. It's called -- if you've heard of the term maybe "just culture."
Q Okay.
A We -- we have -- ours is called fair accountability, that our discipline process is a fair,

Page 169

but also holds people accountable to the process of their work employment, meaning can we coach them, can -- what level do -- does this have to go by based on what's fair, but still holding people accountable.
Q And so in terms of things that you might need to hold an employee accountable for, obviously time and attendance would be one of the issues to hold them accountable to; correct?
A Correct. And we have an attendance policy specifically for that.
Q As well as work performance; correct?
A That would be an annual evaluation opportunity where we do that.
Q If there was a work performance issue that was brought to your attention, could that lead to discipline?
A It could based on our algorithm of coaching versus discipline.
Q Okay. And that could happen even if the employee wasn't due for their annual performance evaluation.
A That is correct.
Q So, in other words, coaching doesn't just happen at the time of annual performance evaluations.
It happens on an as-needed basis throughout

Page 170

the year; correct?
A That is correct.
Q All right. And a work performance issue could involve a patient care issue that an employee requires coaching for; correct?
A That is correct.
Q And patient care issues can also involve patient safety issues.
A That is correct.
Q And all of those things might be things that an employee needs coaching or discipline for throughout the year; correct?
A That is correct.
Q And the hospital would provide that coaching or discipline as events or issues were brought to their attention; correct?
A That is correct.
Q And the purpose of coaching and discipline is to -- one of the reasons, anyway, would be to ensure that the staff is providing the best care to hospital patients.
MR. DE JONG: Object to the form.
But go ahead.
THE WITNESS: I would say, like other things, it's a tool we use to try to make sure we're providing

Page 171

the level of care that we want to, yes.
Q (BY MS. BLAZICH) And if an employee is not providing the level of care that the hospital expects, then they can be subject to termination; correct?
A Through a process, yes, that is correct.
Q I know that you have only been in your current position for three months, but I wanted to know the hiring process that we -- we've been talking about for the last half an hour.
How long has that process been in effect at Northeastern Nevada Regional Hospital?
A I could not say the exact date, but maybe three years with using that -- those specific tools.
Q All right. So I don't know if you're aware, but our case pertains to a gentleman named Mr. Douglas Schwartz, who was a patient at NNRH on June 22nd and 23rd of 2016.
So my question for you is were the hiring processes, what we've been talking about for the last half hour, were they any different in June of 2016?
A Again, I can't say for sure when we implemented certain elements. But things like the behavior assessment tool was in the last three or four years. And -- but all other elements as far as the interviewing and those things would -- would mimic the

Page 172

same, I would say, at that time.
Q So other than potentially the behavioral assessment, the process was substantially the same as it is now?
A Yes.
Q Was there something different that may have been done in June of 2016 in lieu of a -- the behavioral assessment that is now performed?
A Just interview guides, standard interview guides on paper that are not customized to the individual.
Q Are you -- well, how long have you worked at Northeastern Nevada Regional Hospital?
A Twenty-six years.
Q Consistently 26 years without any major breaks or pauses in employment?
A I went per diem for one year.
MR. DE JONG: They're going to name it after her soon.
THE WITNESS: Yeah.
Q (BY MS. BLAZICH) Yeah, they should.
All right. At some point, did you work as an RN at NNRH?
A Yes.
Q Did you ever work in the emergency

Page 173

department?
A No.
Q All right. So in the 26 years that you have worked at the hospital -- I understand that you weren't always in this position, but are you aware of anyone coming to work at the hospital who has not gone through the employment application screening and onboarding process?
A Not that I am personally aware of, no.
Q Based on your knowledge and understanding as the associate Chief Nursing Officer, is there ever a circumstance where somebody would come to work at the hospital and skip the hiring process?
A No.
Q There's no exceptions to the hiring process. All employees must go through it.
A Well, there is -- I'm not going to know the exact details, but I know that if an employee leaves the facility and returns within a certain amount of time, there are certain elements we don't have to -- to do again.
Q Because presumably they were already done for that employee.
A That's correct. That's correct.
Q Other than that example that you just gave

Page 174

me, is there any circumstance that you can think of where the hospital would bring somebody in to work who has not -- has not gone through the hiring process and has never gone through the hiring process?
A I will say with COVID, that has changed that as well. With COVID, there was a potential to onboard people without having to wait for a current Nevada license, for example, because of the waiver the governors allowed, if they have an active license in any state. So COVID and pandemics and emergency things also can change how that looks. That's the only other situation I can think of.
Q Okay. Fair enough.
And so COVID might be an example of a state of emergency that requires people to be brought on on an expedited basis to provide patient care; correct?
A Yes.
Q But if there is no such state of emergency, then every single person providing patient care at NNRH must go through the hiring process.
A To my knowledge and understanding, yes.
Q Would you agree with me that these hiring processes are necessary in order to ensure that qualified candidates and applicants are coming to work at the hospital?

Page 175

A I will reiterate, I think that they are good tools and -- that we use to try to achieve that. But no --
Q The goal --
A Yes.
Q I'm sorry. I didn't mean to interrupt you. Go ahead.
A That's okay. Just no guarantee that it's going to ensure that we have that.
Q Sure.
The goal is to bring in the best and most qualified applicants.
A Yes.
Q The goal is to ensure that those applicants can provide the best possible patient care.
A Yes.
Q And the goal is to ensure that those applicants can help maintain a culture of patient safety at the hospital; correct?
A Yes. That is a -- always our goal.
Q Okay. Without -- without going through that hiring process, would there be any way for a hospital to vet people to come in and work if they haven't gone through the hiring and onboarding process?
MR. DE JONG: Object to form and foundation.

Page 176

THE WITNESS: I -- not to my imagination because I've never seen it done another way, so...
Q (BY MS. BLAZICH) All right. Okay. Without having potential employees go through the hiring and onboarding process, there would be no way to ensure that they met minimum requirements; correct?
A I would say that's true, yes.
Q There would be no way to ensure that they held the licenses that they claimed to have; correct?
A I -- I can't say that -- I can't -- just because I haven't seen that scenario and I can't imagine it, but as a director with my own license, I have to make sure that everybody working for me that's requiring an RN license has that. So I don't see how it could ever get to that -- to that level you're explaining. I -- I have to know that they have a current license for them to be taking care of patients.
Q Fair enough.
And in order to be able to train and orient employees, they have to go through the hiring process; correct?
A That's correct.
Q You mentioned that you've never been aware of a scenario during your 26 years at Northeastern

Page 177

Nevada Regional Hospital where somebody has been brought in to render patient care without going through that hiring process.
A Not outside of those situations that I already said. Not to my knowledge, no.
Q Okay. Have you ever worked anywhere besides Northeastern Nevada Regional Hospital in a nursing or clinical capacity?
A Yes. I worked at Riverton Memorial Hospital in Riverton, Wyoming, as a ward clerk during college, and I worked for a home health company here in Elko when I was pretty young at the hospital here.
Q And I'm assuming that the hospital in Riverton and the home health company also probably had hiring processes in place; correct?
A From someone being hired, yes, they had processes to get me there and hired, yes.
Q And you went through those processes yourself when you were hired to work at Riverton Hospital; correct?
A Yes.
Q And the home health agency that you mentioned.
A Yes.
Q And when you came to work at Northeastern

Page 178

Nevada Regional Hospital, you went through the same hiring process; correct?
A It was a long, long time ago, but I have to think it was the same.
Q Fair enough.
MS. BLAZICH: All right. It's a little earlier than I would normally take a break, but it's kind of a halfway point for me. So let's take a five-minute break, and then we'll come on and we'll wrap up the -- the deposition.
THE WITNESS: Okay.
MS. BLAZICH: All right. Thanks, everyone.
THE VIDEOGRAPHER: We are off the video record at 10:52 a.m.
(Recess taken.)
THE VIDEOGRAPHER: We are back on the video record. The time is 11:02 a.m.
You may proceed.
MS. BLAZICH: Thank you.
Q Ms. Jones, in preparation for your deposition today, did you go through the entire employee file for Nancy Abrams?
A I did review it, yes.
Q And did Nancy Abrams, did she go through the hiring and onboarding process that you've told me

Page 179

about prior to starting her employment at NNRH?
A I can't say that all the elements of the hiring process is in the -- that personnel file. Like employee health things wouldn't be found in there I wouldn't imagine. I -- I can't confirm from the HR standpoint everything from that process that gets put in their personnel file.
Q Okay. Do you believe that she went through the hiring and onboarding process before she started work at NNRH?
A Yes.
Q And you would expect her to go through the hiring and onboarding process before starting work at NNRH; correct?
A Yes.
Q You would never knowingly let somebody who was not a hospital employee or member of the medical staff render patient care at NNRH; correct?
MR. DE JONG: Object to form and foundation.
THE WITNESS: No. If I did not know their employment and credentials to be able to perform care, they wouldn't perform care. Like I mentioned, the shadow. The -- before they're hired, they can't perform care or do anything.
Q (BY MS. BLAZICH) Right. So somebody who's

Page 180

shadowing as part of the employment process, they haven't officially been hired yet; correct?
A That's right.
Q And so they would shadow, but they would not provide any direct patient care at that time.
A Correct.
Q Because they have not completed the hiring and onboarding process.
A Correct.
Q All right. And with regard to Tom Evers, have you had an opportunity to review his employment file as well?
A I did review his file.
Q And do you believe that Mr. Evers completed the hiring and onboarding process before starting work at NNRH?
A Yes. To the extent of those documents and the -- for that process, yes, that are in there.
Q And if he hadn't completed the hiring and onboarding process, he would not be allowed to provide patient care at NNRH; correct?
A That is correct.
Q Did you also review the employee file of Susan Olson in preparation for your deposition today?
A Yes.

Page 181

Q And did Susan Olson complete the hiring and onboarding procedures prior to starting work at NNRH?
A Yes.
Q If she hadn't completed the onboarding and hiring process, she would not be allowed to render patient care at NNRH; correct?
A Correct.
Q Did you review the employee file for Carmen Gonzales?
A Yes, I did review that file.
Q And did Carmen Gonzales complete the application and onboarding process at NNRH before starting work?
A Again, just to what's in the file. I didn't see her application for employment. But for what's in the file, I have to assume that she completed those processes to become employed at the hospital.
Q And she would not be allowed to start work and render patient care without having completed the application and onboarding process; correct?
A Correct.
Q Did you review Donna Kevitt's employee file?
A Yes, I did. I -- I don't actually remember her specifically, but I'm pretty sure it was in there, in the list of files.

Page 182

Q If you need to consult your records or anything like that, you're -- you're welcome to. Just let me know.
A I just don't remember hers.
MR. DE JONG: I mean, I have it here, but I don't know that we can ask somebody to review a 323-page document.
Q (BY MS. BLAZICH) Well, my question's going to be the same as it's been for the other employees, Ms. Jones.
As you sit here today, is it your belief that Ms. -- Nurse Donna Kevitt completed the application and onboarding process prior to starting work at NNRH?
A Yes. I would have to assume that has been completed.
Q Okay. And she would not be allowed to render patient care at NNRH if she had not completed the application and onboarding process; correct?
A That is correct.
Q You would never advocate a practice at the hospital where people are allowed to come in and render patient care without having completed the application and onboarding process; is that fair?
A No. I would say there are circumstances

Page 183

where there are students that come into our building that don't complete that process, but they do render patient care because we have an agreement or a contract to -- that allows them to come in and provide care.
I also mentioned the sleep center that I oversee, but I don't do the hiring process because it's a contracted service. We don't hire and onboard them, but they do come into our hospital as a contracted service and provide patient care.
Q All right. So that would be an exception where there is an actual contract for outsiders to come in and provide a service; correct?
A Correct.
Q And if there is not such a contract, then you would not expect those people to come in and provide patient care at NNRH without having completed the application and onboarding process.
A Yes. I would agree with that.
Q And you would never advocate allowing people to come in and render patient care unless there was a contract allowing them to do so or they completed the application and onboarding process.
A That is correct. I would not.
Q All right. Did you review the employee file

Page 184

for Cindy -- I don't know if it's "Foss" or "Fus." Fus.

A I did. I did, yes.

Q All right. And based upon your review, did Ms. Fus complete all the application and onboarding requirements before starting work at NNRH?

A I have to assume yes.

Q And if she had not completed those hiring and onboarding procedures, she would not be allowed to come in and render patient care; correct?

A That is the process. That's correct.

Q All right. And did you review an employee file for Sylvia Wines?

A Oh, Wines, yes.

Q Wines. Forgive me.

A Yes. Uh-huh.

Q All right. And as you sit here today, is it your belief that Sylvia Wines completed the application and onboarding process prior to starting work at NNRH?

A Yes, that would be my belief.

Q And if she had not completed the application and onboarding process, she would not be allowed to come in and render patient care; correct?

A That is correct.

Page 185

Q The individuals -- just to be clear, the individuals whose names we just went over -- Nancy Abrams, Tom Evers, Susan Olson, Carmen Gonzales, Donna Kevitt, Cindy Fus -- Fus, and Sylvia Wines -- those are all NNRH hospital employees or were at some point in time; correct?

A Were at some point, yes.

Q They were active current employees in June of 2016 at the time Douglas Schwartz was a patient at NNRH?

A I don't have firsthand knowledge of that, but I assume they were active employees at that time.

Q Did -- did you -- have you ever reviewed any of the medical records for Douglas Schwartz?

A I -- I --

MR. DE JONG: Sorry. Shirley, for the purposes of this deposition, she hasn't. I know that -- I think that in the past she had. So I just want to make that distinction.

MS. BLAZICH: Fair enough. Fair enough.

THE WITNESS: Yeah.

Q (BY MS. BLAZICH) So, Ms. Jones, you believe at some point you've reviewed those records.

A Yes. Certain parts of the records I believe maybe the last time.

Page 186

Q All right. And the employees whose files you reviewed in preparation for your deposition today, do you have any recollection of seeing their names in the electronic medical record for Mr. Schwartz?

MR. DE JONG: Object to form and foundation. I don't -- I don't know how much it matters to your question, Shirley, but I don't know that she reviewed the electronic medical records or a PDF copy.

Q (BY MS. BLAZICH) Let me ask it this way, then.

Ms. Jones, as you sit here today, do you know -- do you believe that the individuals, the hospital employees that we've been talking about today, rendered direct patient care to Mr. Schwartz, or do you not know one way or the other?

MR. DE JONG: Object to form and foundation.

THE WITNESS: I do not know one way or the other for all of the employees you've listed, no.

Q (BY MS. BLAZICH) All right. Fair enough.

If their name appears in the medical record as somebody who rendered patient care, would you have any reason to dispute that, what the medical record says?

A No, I would not.

Q All right. You started telling me -- so the

Page 187

sleep center that exists at NNRH, those people that staff that sleep center, they are -- they are employed by an outside source; correct?

A Correct.

Q And the hospital has a contract with that outside source to staff the sleep center; is that right?

A That's correct.

Q Since the sleep center is one of the areas of the hospital that you oversee, I know you're new to your position, but did you have any involvement in negotiating that contract to provide staffing for the sleep center?

A No, I did not.

Q All right. Are you familiar with that contract to provide staffing for the sleep center?

MR. DE JONG: I'm going to object. This is getting kind of proprietary for something that's wholly irrelevant to this case.

MS. BLAZICH: Fair enough. Let me -- I'm just trying to establish some foundation as to whether she's familiar with it or not. I'm not going to go into the details of any kind of proprietary contract.

Q But my question is going to be would you expect that with a outside contracting provider, that

Page 188

they are going through an employment -- an onboarding process for their employees? Would that be your expectation when you're contracting with them to staff the sleep center?

A I think we would expect it. I don't know if it would be outlined in the contract that they do that.

Q Okay. Fair enough.

You're not -- you're not familiar enough with the contract as you sit here today to say whether that would be a requirement or not.

A That's correct.

Q All right. Ms. Jones, have you reviewed any materials in order to help you identify who the members were of NNRH's patient safety or quality care committee around the time of June 2016 through the end of that year?

A I didn't review materials, but I have a list of who was on that committee.

Q How did --

A And I still have it.

Q I see.

And did you compile that list or did somebody provide it?

A Somebody provided it.

Page 189

MR. DE JONG: And I can send you the list, Shirley.

MS. BLAZICH: Okay. That will be great. That will make it easier.

Q Do you have that list handy as well, Ms. Jones?

A Just on his computer.

Q All right. Who provided you with that list?

MR. DE JONG: It was provided to me.

MS. BLAZICH: Okay.

Q So, Ms. Jones, did counsel for the hospital provide you that list?

A Yes.

Q Okay. And do you have any personal knowledge or information pertaining to the names on that list as to whether or not they were actually members of the patient safety committee?

MR. DE JONG: And, Shirley, I'm going to be real -- I mean, the -- the order asks that we produce these names is pretty limited. It's just the names. So I'm not going to let the witness go really any further than that.

MS. BLAZICH: Well, and that's fine. But I think I still am entitled to know what she did to compile this list of names and where the names are coming

Page 190

from.

MR. DE JONG: They came from me.

MS. BLAZICH: Okay. Well, let me let her answer that question.

Q Ms. Jones, the list of names that you have in front of you, was that provided to you by counsel for the hospital?

A Yes, it was.

Q And did you yourself do anything to verify the names on that list?

A No, I did not.

Q Is the list -- well, tell me, is there any date range or reference on that list of names?

A No.

MR. DE JONG: It's the -- the time period from the notice.

Q (BY MS. BLAZICH) As you sit here today, Ms. Jones, is it your belief that the names on that list that you have reflect individuals who were on the patient safety committee and/or quality improvement committee between June 22, 2016, and December 31, 2016?

A I can't personally verify as I didn't research this list.

Q Okay. So you're not positive that that is

Page 191

the date range where these individuals on the list were members of these committees.

MR. DE JONG: I -- again, Shirley, the order says we have to produce the names. So I'm just going to object and instruct her not to answer. Just because your notice is broader than the order doesn't mean you're entitled to ask more questions about it. I'm going by the Court's order.

MS. BLAZICH: I -- I think foundation for what she's about -- the names that she's about to tell us is absolutely important. And that's what this is. It's a foundational question. As the PMK, what did she do to identify these names and to identify the date range. And if the answer is "Counsel gave me the list," that's fine. But --

MR. DE JONG: The order --

MS. BLAZICH: -- I need to know that.

MR. DE JONG: The order supersedes any notice that you filed. So I'm going by the order. I'll provide a list. That's all we're going to do with this.

MS. BLAZICH: Well, I'm going to -- and I'm going to ask her to read in the names of the list. But I think -- I think she's answered the question that the list was provided by counsel.

Page 192

Q And I believe the second question was whether you did anything -- whether you, Ms. Jones, did anything to verify that the list applied to the date range.
MR. DE JONG: She'll read in -- she will read in the names, and then that's -- that's it.
Q (BY MS. BLAZICH) Okay. Does the date range of June 22, 2016, to December 31, 2016, apply to the -- the list of witnesses that you have in front of you?
MR. DE JONG: Object to form and foundation.
THE WITNESS: There's no date of the range for these people. It's just people's names on a list.
Q (BY MS. BLAZICH) So is it fair to say, then, that you as you sit here today do not know whether the date range of June 22, 2016, to December 31, 2016, applies to the list of names before you?
A I don't have personal knowledge of it, no.
Q All right. Okay. Tell me the names on the list.
A Rebecca Sharp. Chandra King. Cody Bright. Julie Jerns. Marla Asson. Robin Web. Dr. Mardini. Leslie Ayans.
Q All right. Is that everybody?

Page 193

A That is everybody on the list, yes.
Q All right. Are there any initials or anything after any of the names, such as RN? MD?
A Their job title is next to them.
Q Okay. Can you run through the list one more time and tell me the job title that's on -- that's next to each name?
A Yes. Rebecca Sharp, quality assistant. Chandra King, quality assistant. Cody Bright, pharmacy director. Julie Jerns, interim surgery director. Marla Asson, lab director. Robin Web, infection control. Dr. Mardini, pathologist. Leslie Ayans, director of quality patient safety officer.
Q All right. Is there any other information on the list you're looking at?
A No.
Q Does it -- does the list you're looking at identify who the chair of the patient safety committee was?
A The list does not.
Q It doesn't have that information?
A No, not on the list.
Q Are there any dates on the list as to any meetings that these people whose names you read attended?

Page 194

A No, no dates.
Q Have you read to me everything that's on the list that you're looking at?
A Yes.
Q Ms. Jones, do you have a copy of the hospital's mission and values in front of you?
And I'll pull it up --
MR. DE JONG: Yeah, if you could project it, that would be great.
MS. BLAZICH: I will.
MR. DE JONG: I'm real territorial with my laptop.
MS. BLAZICH: I can see that.
Q All right. Ms. Jones, can you see the document that I'm displaying on my screen entitled Northeastern Nevada Regional Hospital Organizational Mission, Vision, and Value Statements?
A Yes.
Q All right. And have you seen this document before?
A Yes.
Q Did you review this document in preparation for your deposition today?
A Yes.
Q And is it your belief that this document

Page 195

reflects -- well, is that -- this is the current version of this document that was in effect in June of 2016 when Mr. Schwartz was a patient at NNRH?
A Yes.
Q All right. And is the same version still in effect today or has it been changed?
A I can't say word for word, but I can -- I know that that's still our mission and vision and our values.
Q All right. So the -- under "Purpose," it states, "To provide for the establishment of a mission, vision, and values statement for the hospital, its articulation, review, revision, and communication."
Did I read that correctly?
A Yes.
Q This -- I'm going to call it the mission statement. This is the document that I'm referring to.
Does -- is this applied hospital wide?
A Yes.
Q And is there a separate actual mission statement? Because this sort of appears to be a policy and procedure to have a mission statement. And so my question for you is whether there's a separate

Page 196

document that is the mission statement.
A No. And that's why the purpose says that we use it as a policy so we can articulate it and communicate it as a policy.
Q Okay. So this is both the policy and the mission statement.
A Yes.
Q All right. What is the hospital's mission statement or what was it in June of 2016?
A Making Communities Healthier.
Q All right. And does that mission statement appear on your website at this time, if you know?
A I don't know. I -- I can assume, but I don't know for sure.
Q Okay. Do you know if this statement appeared on your website in June of 2016?
A I do not know.
Q Is the mission statement displayed anywhere at the hospital that you are aware of?
A I -- I know it was at some point at the main entrance. I can't tell you honestly if it's still there. I've been here so long, I don't see things anymore that have been there forever. So I do know I have seen it displayed on walls here before, yes.
Q All right. And when you say you've seen it

Page 197

displayed at the main entrance, is that the ER entrance or is that a different entrance?
A A different entrance.
Q Do you know if the mission statement is displayed anywhere in the emergency room?
A I have seen it in the ER, outside of the ER registration window. I don't know if it's still there current, but I have seen it there before, yes.
Q Okay. What is NNRH's intent and meaning behind the mission statement where it says "Making Communities Healthier"?
A That is our goal and aspiration and purpose to being here in our community, is to try to help make it a healthier place for our community members.
Q What does NNRH do in order to attempt to achieve its mission statement?
A So we do all kinds of things. I mean, there's -- every day we're doing things to try to achieve that mission statement in our daily actions and care that we provide. But we are accredited by various entities -- the Joint Commission, the American College of Cardiology -- showing that we achieved certain standards. We go and provide community service or education and training. I had a team just last Friday teaching all the Spring Creek football

Page 198

coaches how to operate AEDs that we donated. So we're out in the community teaching people how to do CPR.
We have various classes, like breastfeeding classes, that community members can come to. Diabetes -- diabetes counseling and classes. We have a support group for different people with different disease processes or chronic illnesses that are available to members of the community.
We advocate for smoking cessation in health plans with other employers in the community. There's a litany of things. I mean, it's our everyday what we do, trying to make communities healthier.
Q Is part of the hiring and onboarding process that you go through with your employees also directed at achieving your mission statement of making communities healthier?
A I would say trying to -- the vision, you know, making it a place where employees and physicians want to work and people come for healthcare. If we're doing those visions, then yeah, we have to have the right people here to achieve our mission statement of making communities healthier.
Q And you need to be sure that you're hiring and training the best possible staff in order to make communities healthier; correct?

Page 199

A Yeah. I would say there's a lot of elements that go into that, yes.
Q And that's one of them. Hiring the best possible staff and employees is -- is part of the way to achieve that goal, that mission of making communities healthier.
Would you agree with that?
A Yes. And just like I said before, with the shadow and the different things we do to make sure we're also the right fit. If they don't agree with our mission and vision, they probably should -- don't want to be here if that's not their goal as well.
Q Okay. Would it be consistent with NNRH's mission and value of making communities healthier to allow non-staff, non-employees to provide patient care at NNRH?
A No. I think we've gone over the situations that non-employees would be administering care in our building, and that would be the only reason.
Q Those were -- right. Those were the situations like if there's an -- a state of emergency; correct?
A Right.
Q Or if there's a contract for people to come in and provide patient care; correct?

Page 200

A Correct.
Q But outside of those examples that you've given me, you would agree with me that it would be inconsistent with NNRH's mission and values to allow outsiders who are not members of the medical staff and who are not employees and who are not working subject to a contract to come in and render patient care.
A That's correct. I would say NNRH, the facility, does not allow that.
Q And that would not serve NNRH's mission of making communities healthier; correct?
A Correct.
Q Would you also agree with me that it would be inconsistent with NNRH's mission statement of making communities healthier if NNRH were to allow unnecessary medical procedures to be provided -- performed upon patients?
MR. DE JONG: Object to form and foundation.
MS. BESTICK: Join.
MR. WESTERBERG: Join.
THE WITNESS: Can you repeat the question?
Q (BY MS. BLAZICH) Sure.
Would you agree with me it would be inconsistent with NNRH's mission statement of making communities healthier if it were to allow unnecessary

Page 201

medical procedures to be performed upon patients?
MR. DE JONG: I'm going to -- objection.
THE WITNESS: I would have to say that this is a mission for us to try to achieve a goal, and I don't know how unnecessary procedures relates to this goal.
Q (BY MS. BLAZICH) Well, unnecessary procedures wouldn't relate to the goal because if the mission is to make communities healthier, you would not want unnecessary medical procedures performed on those community members; correct?
MR. DE JONG: Same objection.
THE WITNESS: I would say that's correct, determining on who's saying that that is an unnecessary procedure.
Q (BY MS. BLAZICH) Fair enough. And, you know, I'm giving you a hypothetical.
But you are --
A Okay.
Q -- a registered nurse by trade; correct?
A Yes.
Q So you have an understanding as to what I mean when I say medically necessary or -- or medically unnecessary procedures, generally speaking.
A Yes.
Q All right. And you would not -- having

Page 202

unnecessary medical procedures performed upon patients, that would not be consistent with NNRH's mission statement of making communities healthier; correct?
MR. DE JONG: Form and foundation.
THE WITNESS: I would say in a very long way, yes, that is correct.
Q (BY MS. BLAZICH) Do you believe that it would be reckless for a hospital such as NNRH to allow outside individuals who are not employees, who are not members of the medical staff, and who are not working subject to a contract to come in and provide patient care?
MR. DE JONG: Object to form and foundation.
THE WITNESS: I --
MR. DE JONG: You can go ahead and answer.
MS. BLAZICH: You can answer.
MR. WESTERBERG: Join the objection.
THE WITNESS: I would say that's why we have these policies and these guidelines in place, to make sure we're doing -- we're getting the right people in our building to take care of patients. I -- I think that's why we use that tool and that policy so that doesn't happen.
Q (BY MS. BLAZICH) Right. Because if people

Page 203

were being brought on to render patient care without being a member of the medical staff and without being subject to the hiring and onboarding process, that would be reckless of a hospital.
Would you agree with that?
MR. DE JONG: Object to the form and also the characterization of something as reckless without any other information.
Q (BY MS. BLAZICH) You can still answer, Ms. Jones.
A I would say there's a reason we don't do that, because there's no structure around knowing that that person is appropriate to care for that patient. So that's why there's a policy.
Q The policy is to prevent that from happening, having unauthorized people coming in and rendering patient care.
MR. DE JONG: Object to the form.
What policy are we referring to?
MS. BLAZICH: I think she was referring to a policy.
I'm going to take this -- this down.
THE WITNESS: On -- onboarding people is what I was referring to, and I would say there's many reasons that there's a structure and a guideline for that. I

Page 204

can only assume that that's one of them as I have never seen it and seen that that is why we had to do something like that.
Q (BY MS. BLAZICH) And forgive me, I don't believe that you answered my question before.
A Okay.
Q But as a registered nurse and as the Associate Chief Nursing Officer and as somebody testifying on behalf of NNRH today, would you agree with me that it would be reckless for a hospital to allow an outside individual who is not a member of the medical staff and who is not an employee and who is not working subject to a contract to come in and render patient care?
MR. DE JONG: Again, object to form. Foundation. It's an incomplete hypothetical.
THE WITNESS: I would say outside of the conditions I provided, I don't know why we would do that, and there would be no interest in doing that.
Q (BY MS. BLAZICH) And it would be reckless to allow that to happen.
A I would say in most circumstances, yes.
Q And could you understand how a member of the community in Elko might consider it reckless for a hospital to allow outsiders who are not members of the

Page 205

medical staff and who are not employees of the hospital and who are not working subject to a contract to come in and render patient care?
MR. DE JONG: Objection. It's an incomplete hypothetical. If you're referring to the facts of this case, then directly refer to them.
Q (BY MS. BLAZICH) You can still answer the question.
A Can I ask a question?
Q Sure.
A Just to clarify that. I don't know how a hospital, which is a building, can do that. It sounds like an individual would have to allow that to happen. So an entity couldn't. A person would have to.
Q A person within the hospital with the authority to do that would have to do it; correct?
A I wouldn't say with authority. I would say anybody could do something they shouldn't do in our hospital that hasn't been given authority to do that.
Q Fair enough.
Anybody can do pretty much whatever they want to.
A Sure.
Q And if the hospital learns that somebody is doing things at the hospital outside of their

Page 206

authority that impacts patient care, then the hospital has a duty to respond and react.
Would you agree with that?
MS. BESTICK: Form and foundation.
Q (BY MS. BLAZICH) I'm sorry. I didn't hear you over the objection.
Could you repeat your answer?
A I would say if -- if people of authority found out that something was happening, yes, it is their responsibility to rectify the situation.
Q And specifically if people with authority at NNRH became aware that individuals who are not employees and who are not members of the medical staff and who are not working subject to a contract are coming into the hospital and rendering patient care, you would expect the hospital to do something about that; correct?
MR. DE JONG: Objection. It's an incomplete hypothetical.
What people are you referring to, Shirley?
MS. BLAZICH: We'll get there.
MR. WESTERBERG: Same objection.
MS. HUETH: This is Chelsea. I'm going to object as well on foundation and outside the scope.
MS. BESTICK: Join in that objection.

Page 207

Q (BY MS. BLAZICH) You can answer, Ms. Jones.
A Okay. I would also say it depends on your definition of who's in authority.
But yes, I think if leaders -- if leadership of the hospital were aware of practices that should not be happening, it is their responsibility then to remedy that issue.
Q In this particular case, do you know who Barry Bartlett is?
MR. DE JONG: I would say this is really beyond the scope of a -- of the -- the PMK notice.
MS. BLAZICH: Well, you guys are objecting to foundation and telling me to get more specific as to the facts of this case --
MR. DE JONG: Which we're required to do.
MS. BLAZICH: -- and that's what I'm trying to do.
So if you want to withdraw --
MR. DE JONG: I know what you're doing.
MS. BLAZICH: I know. But hold on a second.
Like, if you want to withdraw your foundation objection, then I don't need to get into these questions. But you guys are saying that I need to lay a foundation as to the specifics of this case, which is what I'm trying to do.

Page 208

MR. DE JONG: She was not designated a PMK for paramedics rendering treatment in the ED. So any questions along those lines I'm going object to and instruct her not to answer.
MS. BLAZICH: Well, my question is going to be whether or not -- whether she knows who these individuals are and whether they're employees of the hospital. And that's really all I intend to ask.
MR. DE JONG: Okay. Well, that's going to have to be a new notice, a properly-noticed PMK.
MS. BLAZICH: Well, I think that she should be entitled to answer that if she knows the answer to it today because that is what -- the information that I need to lay a foundation --
MR. DE JONG: She --
MS. BLAZICH: -- for the specifics of this case, which you all have objected to.
MR. DE JONG: She's not answering any questions about the scope of paramedics working in the ED. That's completely off topic.
MS. BLAZICH: No, I'm not going to ask her questions about the scope of paramedics working in the ED. I'm going to ask her -- I would like to ask her if she knows who Barry Bartlett is and if he has ever been an employee of the hospital.

Page 209

MR. DE JONG: Okay. Then give a new notice --
MS. BLAZICH: Those two questions.
MR. DE JONG: Give a new notice, and we'll notice -- we'll -- we'll get you the person that can talk about that.
MS. BLAZICH: Okay. So are you instructing her not to answer that -- those questions?
MR. DE JONG: She's not answering because it's far, far beyond the scope of the PMK notice for employees of the hospital, your specific notice. So no, we're absolutely not going there.
MS. BLAZICH: Fair enough.
Q Let me -- I would ask the same question about Ronnie Lyons.
Do you know who he is, and has he ever been an employee of the hospital?
MR. DE JONG: Nope, we're not doing that either.
MS. BLAZICH: All right. So for the record, this is -- these are questions that I am asking based on the objections that have been made during this deposition, and specifically an objection about lacks -- lacking foundation. I am attempting to lay that foundation, and the witness is being instructed not to answer.
MR. DE JONG: Yes, she's being instructed not to

Page 210

answer any questions outside of the scope of the PMK notice.
MS. BLAZICH: Fair enough.
Is any basis of you instructing the witness not to answer based on privilege?
MR. DE JONG: That's such a vague question that there's no way I can answer that.
MS. BLAZICH: Okay. Fair enough.
So at this point, you have not made any objection based on privilege for the record.
Q Ms. Jones, let me ask you this.
I asked you kind of generally about a hospital allowing outsiders to come in and render patient care. Let me ask you specifically as to NNRH.
Would you agree with me that it would be reckless for NNRH to allow outsiders to come in and render patient care who are neither members of the medical staff nor employees of the hospital nor working subject to a contractual agreement?
MS. HUETH: Objection. Outside the scope. Calls for a legal conclusion.
MS. BESTICK: Join.
MR. DE JONG: What -- what topic is this under, Shirley?
MR. WESTERBERG: Join.

Page 211

MS. BLAZICH: Mission and values.
MR. DE JONG: Yeah, it's outside the scope.
To the extent you can, you can answer. But we're objecting it's outside the scope.
THE WITNESS: I would say yes, we don't allow people who haven't been through the correct process to take care of patients as a facility at this hospital.
Q (BY MS. BLAZICH) That would not -- doing that would not allow -- would not make the community healthier; correct? Allowing outsiders to come in and render patient care?
A I -- I have a hard time reaching that. I mean, what if it was a great doctor that came in and did great things and made the community actually healthier? So I don't see the reach for that. I don't as a clinician. I'm sorry.
Q But you would have no way of knowing if it was a great doctor rendering great patient care unless you -- unless that doctor went through the credentialing process; correct?
MR. DE JONG: Object to form and foundation.
And we're talking about different things. We're talking about doctors that are independent contractors versus employees of the hospital versus paramedics coming into the hospital.

Page 212

So she wasn't designated to talk about independent contractors coming into the ED or independent physician contractors.
MS. BESTICK: Join in that objection.
MR. WESTERBERG: And join as well.
MS. HUETH: This is Chelsea. Incomplete hypothetical.
Q (BY MS. BLAZICH) You can still answer my question, Ms. Jones, if you remember it.
MR. DE JONG: Can we read it back?
MS. BLAZICH: I don't remember it either.
So please, Vicki, read it back.
(Question read.)
MR. DE JONG: Yeah, all the same -- the same objections.
What are we -- since when are we talking about doctors and credentialing, Shirley?
MS. BLAZICH: She brought it up in her answer, and so that's -- I'm just following up on something that she said.
THE WITNESS: And -- and I would answer that I don't think credentialing process, that whole process dictates a good doctor and determination of a good doctor. I would say that's irrelevant.
Q (BY MS. BLAZICH) All right. With regard to

Page 213

hospital employees, though, you wouldn't have any way of knowing whether an employee was good and competent and capable unless they went through the hiring and onboarding process; correct?
A No. Again, I disagree. I think that you are putting all the weight on the hiring -- hiring and orienting process to determine a good employee. And the weight is not all on that one end.
You can get through an entire hiring and orienting process and months down the road determine that whatever -- however you want to define good employee is not what you thought it was at the hiring and orienting. So I -- I think they're not one and the same.
Q Fair enough. But that's the beginning of the process, correct, to determine who the good employees are?
A Again, I would say you cannot determine they're good because of the hiring process. Anybody can present up front.
Q Fair enough.
You can determine, though, that they meet minimum requirements for employment.
A That is --
Q Correct?

Page 214

A Yes, that is correct.
Q And you can determine whether they have current and active licenses for their position; correct?
A That is correct.
Q And you can determine whether they've met a background check to be cleared for employment; correct?
A That is correct.
Q And you wouldn't be able to do any of those things if the employee did not go through the application and onboarding process.
MR. DE JONG: Object to form and foundation. Incomplete hypothetical.
MR. WESTERBERG: Join.
THE WITNESS: No. We wouldn't know those things per se if they didn't go through that process.
Q (BY MS. BLAZICH) That -- that hiring and onboarding process is how the hospital gathers that information about its prospective employees; correct?
A Correct.
MR. DE JONG: Hey, Shirley?
MS. BLAZICH: Yeah.
MR. DE JONG: We're over six hours without breaks. And I just want to make you aware of that.

Page 215

MS. BLAZICH: I think I'm almost -- I think I'm done. Give me -- so you don't have to worry.
Let's take a five-minute break. I'm going to go over my list. I think I'm done, but I may have one more question, and then we can wrap it up. So -- so we won't push the seven hours. Not on this one anyway, Ricky.
MR. DE JONG: It was more for your future -- whatever we're going to call this. I don't know if you want to do this again with somebody else, so --
MS. BLAZICH: I really don't.
All right, thanks, guys. Let's take a break.
THE VIDEOGRAPHER: We are off the video record at 11:47 a.m.
(Recess taken.)
THE VIDEOGRAPHER: We are back on the video record. The time is 11:53 a.m.
You may proceed.
MS. BLAZICH: All right. Thank you.
Q Ms. Jones, have I given you a full opportunity to answer all of my questions today?
A Yes.
Q Are there any questions that you wish to change your answer to at this point?

Page 216

A No.
Q Okay.
All right. Thank you. I don't have any further questions for you today. Thank you for your time.
MR. DE JONG: I've just got a couple follow-up questions.
EXAMINATION
BY MR. DE JONG:
Q Becky, you testified today about the onboarding process and hiring and training of NNRH employees; correct?
A Correct.
Q And you testified extensively about your experience and training and knowledge of that process; correct?
A Correct.
Q Do you now or have you ever played a role in evaluating the role that paramedics have in the ED?
A No.
Q Do you have any knowledge about the role and interchange between paramedics and providers in the ED?
A No.
Q You don't in your capacity evaluate the role

Page 217

that paramedics play in the ED and the interchange that they have with providers in the ED; correct?
A Correct.
MR. DE JONG: That's all the questions I have.
MS. BLAZICH: I don't have any other questions.
MS. BESTICK: This is Alissa. I don't have any questions. Thank you.
MS. HUETH: This is Chelsea. I don't have any questions either.
MR. WESTERBERG: This is Austin. I just have a couple follow-up questions I wanted to discuss.
EXAMINATION
BY MR. WESTERBERG:
Q Ms. Jones, my name's Austin Westerberg. I'm one of attorneys for REACH Air.
And you've previously testified at deposition in this case; correct?
A Correct.
Q And that was in the same role as a person most knowledgeable?
A Yes.
Q Do you agree that your prior testimony from the earlier deposition is accurate?
A Yes.
Q You testified regarding the hiring process

Page 218

and onboarding process.
That process does not apply to outside caregivers such as critical care transport; is that correct?
A Correct.
Q Is it typical of the hospital for outside providers such as paramedics or critical care transport to provide care in the emergency department?
MR. DE JONG: To the extent you know.
THE WITNESS: Will you repeat it? I didn't hear if you said "typical" or "atypical."
Q (BY MR. WESTERBERG) I said "typical."
A Will you repeat the whole thing? Sorry.
Q Yeah. Let me -- let me rephrase that.
Do paramedics or critical care transport teams, do they regularly provide care in the emergency department at NNRH?
A I would say yeah. When they come in to package a patient to take them, yes, they do assume care for a patient.
Q And it's appropriate for those providers to come and provide care; would you agree?
MR. DE JONG: Since -- I don't think she's ever worked in an ED, so...
MR. WESTERBERG: I'm just trying to clarify --

Page 219

Shirley asked some questions about when, you know, people from the street essentially can come in and provide care.
Q And so I just want to clarify that paramedics, emergency transport, that's an appropriate situation for people to come in and provide trans- -- or provide care.
A Yes. I would say it's -- I routinely see as an employee of the hospital transport people in our facility at bedside.
Q And is it consistent with the hospital's mission for outside providers such as paramedics and critical care transport to come in and assist with patient care?
A Yes.
MR. DE JONG: To the extent you know in the ED.
THE WITNESS: Yeah. I think they're essential collaborative healthcare workers with us to be able to deliver care to our community, yes.
Q (BY MR. WESTERBERG) One more thing here.
I just want to review my notes and make sure that's all I have.
And if an outside provider such as a critical care transport team is requested to come to the hospital to provide care, would you agree that

it's appropriate for them to provide treatment?
MS. BLAZICH: Objection. Outside the scope.
THE WITNESS: From my understanding of transport, yes. They're coming in to take over care of a patient and -- and continue care.
MR. WESTERBERG: I have no further questions. Thank you.
MS. BLAZICH: I don't have anything else.
MR. DE JONG: Did you -- the last time you did a dep, did you review the deposition or did you just waive signature? Becky?
THE WITNESS: Say it again.
MR. DE JONG: Do you remember reviewing your previous deposition? Did you review it or did you waive signature?
THE WITNESS: I think I signed it.
MR. DE JONG: Okay.
THE WITNESS: I think I signed it.
MR. DE JONG: Okay. We'll -- we'll take the copy, and I'll arrange signature.
MS. BLAZICH: Thank you.
Oh, you're muted, Becky.
THE VIDEOGRAPHER: Thank you.
This concludes the deposition. The time is 11:59 a.m., and we are off the video record.

(The deposition was concluded at 11:59 a.m.)

CERTIFICATE OF DEPONENT

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I, REBECCA JONES, deponent herein, do hereby certify and declare under penalty of perjury the within and foregoing transcription to be my testimony in said action, that I have read, corrected, and do hereby affix my signature to said transcript this _____ day of _____, 2021.

_____
REBECCA JONES
Deponent

REPORTER'S CERTIFICATE

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

I, Vicki Turner, a certified court reporter in Clark County, State of Nevada, do hereby certify:
That I reported the taking of the deposition of the witness, RABECCA JONES, commencing on August 19, 2021, at 10:04 a.m.
That prior to being examined, the witness was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth.
That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true, and accurate transcription of shorthand notes taken down at said time.
I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action.
IN WITNESS WHEREOF, I have hereunto set my hand in my office in the County of Clark, State of Nevada, this 30th day of August 2021.

Vicki Turner

Samaritan" provisions. The next addition to S.B. 2 was subsection 5 on page 5 of the bill that would give total immunity to medical doctors, osteopathic physicians, and dentists who, in good faith, provided medical care to a patient free of charge at a nonprofit or governmental health care facility.

Assemblyman Marvel asked if that language was the "Good Samaritan" statute. Ms. Lang confirmed it was contained in the Good Samaritan statute.

Ms. Lang called the committee's attention to Section 2 of S.B. 2, when Chairman Anderson announced that the Ways and Means Committee would be meeting at 2:30 p.m., and that required a recess of his committee at 2:15 p.m. Chairman Anderson called new witnesses to the table and summarized the current discussion centered on S.B. 2. He explained there were committee concerns regarding the language on page 2 and the expansion of emergency room coverage to additional hospitals. Chairman Anderson asked the witnesses to clarify the intent of the language.

Gus Flangas, an attorney representing the Physicians Task Force, introduced his colleagues, Dr. Robert McBeath (to his left) and Dr. Michael Daubs (to his right).

Assemblywoman Parnell voiced concern about the addition of a new population of doctors and the clear standard to be met for the $50,000 liability coverage. If a clear standard was established, her second concern was that the determination would not be made until the matter reached a court of law. She asked for clarification on that process.

Before addressing Assemblywoman Parnell's concerns, Mr. Flangas offered to review the background information that led to insertion of the language. The University Medical Center (UMC) Trauma Center in Las Vegas was extremely vital to Clark County and areas of Arizona and California. The UMC Trauma Center closed its doors in July for 10 days. The impact was devastating to the community and was foretelling of events to come in northern Nevada. Mr. Flangas explained that UMC was a state facility, and it fell under the $50,000 limitation. The employees of UMC also fell under that limitation. The reason for the bill was to help the independent doctors who worked at UMC, but, in fact, were not employees of the UMC Trauma Center. Those doctors were paid $40 per hour to work on a voluntary basis. When they listed the UMC Trauma Center on their malpractice insurance applications, their premiums increased significantly. In Mr. Flangas' judgment, those doctors needed protection.

Mr. Flangas illustrated his point with an example of an independent doctor treating a patient at the UMC Trauma Center. That patient became his patient (i.e., professionally bound to continue with the care and treatment of that patient). The language that was inserted was somewhat designed to add more protection because of that obligation to perform follow-up work on that patient, regardless of location or time. Mr. Flangas explained the previous draft of the bill had no provision for follow-up work, and that caused great concern. It exposed the physician to the loss of the $50,000 coverage as originally drafted. The new language remedied that situation

with the "rebuttable presumption" language. If there was an injury to the patient, it would be presumed to have occurred during the course of treatment for that trauma.

Chairman Anderson interrupted and reminded the witnesses that time was running out for questions from the committee. Mr. Flangas acknowledged the concern and summarized the issue of "rebuttable presumption."

Assemblywoman Parnell interrupted to clarify for the witness that her concern was not that section of the bill. She stated emphatically that there was not one person who would argue the need to protect the trauma doctors in Nevada. Assemblywoman Parnell voiced her concern over language in S.B. 2 that added a new population of doctors who, with special circumstances, would have that same $50,000 liability protection. She voiced additional concern over a clear definition of when the coverage would be applicable and who would make that determination.

Dr. Michael Daubs, an orthopedic surgeon, offered to respond. There existed clear definitions in the *Nevada Administrative Code* that defined a "trauma patient." If a patient qualified under that definition and was treated at a facility that was not a designated trauma center, the doctor would be protected by the proposed legislation.

Assemblywoman Cegavske reiterated an earlier question regarding the terminology "a physician" and asked if that included anesthesiologists in the treatment of trauma patients. Mr. Flangas replied in the affirmative.

Assemblyman Dini asked if coverage included nurse anesthesiologists. Mr. Flangas replied a nurse anesthetist would not be covered under that language. Chairman Anderson requested clarification from the Committee Legal Counsel. Ms. Lang called the committee's attention to subsection 1, page 2, line 17, where it read "an employee of a hospital who renders care." Ms. Lang explained it referred back to the nonprofit hospitals and centers. In regard to a for-profit facility, the same language was provided in subsection 2.

Following Chairman Anderson's clarification, Ms. Lang continued with her testimony and stated it applied to employees of a hospital. It was provided under both subsection 1 and subsection 2. In governmental hospitals, employees were already covered under the sovereign immunity statute. As such, they were not included in that part of the bill, but they did have coverage nonetheless.

Assemblyman Brown, addressing Assemblyman Dini's concern of nurse anesthetists, stated he believed that group had to carry their own professional insurance and were not necessarily classified as employees of hospitals.

In way of clarification, Dr. Michael Daubs stated it was his understanding nurse anesthetists were employed by hospitals.

Assemblyman Dini reiterated his comparison between lines 32-39 on page 2 (i.e.,

"serious medical condition requiring immediate medical attention") versus the language on line 2 of page 3 where it stated "acute life-threatening medical conditions." He observed there was a difference in standards between the two cited areas of S.B. 2.

Gus Flangas offered to respond and stated there was no clear answer to that concern. He suspected it happened in the drafting of the bill, and he was unsure if there was any actual distinction in the language. Chairman Anderson predicted that upcoming testimony from the hospital administrators and their attorney would resolve that issue.

Assemblyman Marvel asked when the $50,000 protective cap expired for a patient judged to be stabilized and who made that determination. Dr. Daubs offered to respond, and he acknowledged the issue of stabilization was a difficult one in the medical community. The language was added because the doctor's initial contact with a patient was usually the first of several appointments. From his standpoint, a patient was stabilized if he was discharged from the clinic; the condition had been treated and he did not have to return to the clinic.

Assemblyman Marvel summarized by saying the $50,000 cap might be in place for a period of time. Dr. Daubs replied in the affirmative and, for many injuries, stated it could be 6-12 weeks.

Dr. Robert McBeath clarified that attempting to place a definite time limit on the $50,000 was not recommended. The intent was tied to the actual relationship between the doctor and patient as well as the nature of the injury. That relationship commenced when the doctor first treated the patient at the trauma center. The doctor's judgment that the patient could be discharged from his care was the essential point.

Assemblyman Marvel asked if, as a matter of formality, the physician waived his liability at the point the patient was stabilized. Was the doctor required to sign-off; Mr. Flangas replied that would not be feasible under the law to have the doctor waive his rights for personal injury, especially in a trauma situation. As far as the issue of time limit expiration, Mr. Flangas stated that if a charge of malpractice was raised during treatment, it would be essential to prove that the malpractice actually occurred during that treatment. That was the essence of the bill. If it could be demonstrated that the malpractice occurred in the follow-up treatment, the presumption no longer was in place. It would become a malpractice action based on events during follow-up actions.

Chairman Anderson illustrated the issue with an example of a patient who showed signs of cardiac arrest and went to the emergency room of a rural hospital. After the patient was stabilized, he was sent home with the expectation that his treatment would continue with his personal physician. Chairman Anderson asked if there was a point in time when the $50,000 coverage no longer applied in that case. He added that previous testimony indicated the question would become an arguable point in court proceedings.

Mr. Flangas replied that theoretically the $50,000 cap would continue as a presumption. In the hypothetical case posed by Chairman Anderson, Mr. Flangas took the example a step further. Several months passed uneventfully and then the patient had symptoms that caused him to see his doctor. The patient was erroneously told he had indigestion and not a heart attack. That case would be considered malpractice due to subsequent events outside of the trauma center, and the $50,000 cap no longer applied.

Chairman Anderson modified his hypothetical case and stated the patient showed up at the emergency room convinced he was having a heart attack. The attending physician diagnosed the condition as indigestion and sent the patient home. The patient died of a massive coronary attack in the hospital parking lot. Chairman Anderson asked if the $50,000 cap covered the physician and could be recovered by the patient's family.

Mr. Flangas requested clarification if the hypothetical patient had presented to the emergency room at the UMC Trauma Center. Chairman Anderson replied the patient was in Carson City. Dr. Daubs stated a heart attack was not considered a trauma and therefore would not be covered.

Dr. McBeath acknowledged there was some confusion in the language. The testimony in the Senate had centered on the example of the trauma victim being seen at another facility, not necessarily at UMC. During the Senate hearing, Dr. McBride illustrated the point with a case of a gunshot wound being handled at a community hospital.

Chairman Anderson voiced confusion and was still attempting to fully understand his hypothetical case. Because Nevada only had three designated trauma centers (i.e., Las Vegas, Reno, and Fallon), the likelihood of being seen in an emergency room of a hospital was very high for many Nevada citizens.

Dr. Daubs requested clarification if the hypothetical scenario was the example of a patient who was judged to be a trauma patient, but was not seen at a designated trauma center. Chairman Anderson read from lines 35-37 on page 2 of the bill "enters a 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." Dr. Daubs responded the heart attack would not fall under the trauma criteria.

Risa Lang, Committee Legal Counsel, asked if the witness was referring to the way they defined the situation, for example, going into a designated trauma center. She voiced confusion over why a heart attack would not be judged as a serious medical situation for a person in an emergency room or a trauma center. She called attention to subsection 2 that did not refer to designated trauma centers, but specifically addressed hospitals. In the example given, it would be an acute life-threatening medical condition, and she was unsure why a heart attack did not fall into that category.

Dr. Dan McBride, a member of the Physicians Task Force and President of the American College of Surgeons, approached the witness table and offered to clarify the issue. In testimony before the Senate, the discussion centered on limiting the coverage to patients with traumatic injuries. It was never the intent to extend blanket coverage to all emergency room patients, such as heart attacks. It was designed to extend the same liability coverage of physicians in the trauma center to physicians treating trauma cases in other facilities and hospitals.

Chairman Anderson emphasized the need for language that was sufficiently narrow for interpretation purposes.

Gus Flangas asked Dr. Daubs to address the issue. Dr. Daubs echoed the testimony of Dr. McBride and stated it was never the intent to include all medical cases, such as heart attacks. Dr. McBeath declared the core of the issue was in the definition of a trauma patient, and there were statutory definitions in place. He advised the statutory definitions would provide guidance for the bill language.

Chairman Anderson thanked the witnesses for their testimony and called representatives of the hospital association to the witness table. Robert Barengo, representing Sunrise Hospital, commenced testimony and explained the bill had been sponsored by the physicians. The heart of the issue was the treatment of trauma cases in all medical facilities. All hospitals received trauma patients. Physicians had a major concern that by treating a trauma patient in an emergency room, their liability might differ from what they would have had at a designated trauma center. Mr. Barengo described the bill as an attempt to have the designation of "trauma" follow the patient to whatever facility he entered for treatment.

Mr. Barengo described Section 1 as addressing the trauma centers, whereas Section 2 attempted to bring in all hospitals that treated trauma. Line 2 of page 3 included the language "acute life-threatening," and he viewed that as an attempt to define "trauma." A more refined definition of trauma was located in NRS 450B.105. Mr. Barengo suggested the addition of that definition to solve the problem. A physician treating any patient in any facility who met the definition of traumatic condition would be under the cap.

Assemblyman Oceguera voiced his opinion that because the language was so overly broad, it would invite unintended interpretations. He agreed there were established definitions of "trauma" in the NRS 450B.105 that would solve the issue.

In response to Assemblyman Oceguera, Mr. Barengo reminded the committee the use of that definition of trauma would bring into play the *Nevada Administrative Codes* (i.e., NAC 450B.798 and 450B.770) that dealt with the trauma issue.

Chairman Anderson called a committee recess with a request to reconvene at 4:30 p.m.

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

DIANE SCHWARTZ, individually and as Special Administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased,
Plaintiff,
vs.
DAVID GARVEY, M.D., an individual; BARRY BARTLETT, an individual (Formerly Identified as BARRY RN); CRUM, STEFANKO & JONES LTD, dba RUBY CREST EMERGENCY MEDICINE; PHC-ELKO INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, etc., et al.,
Defendants.

NO. CV-C-17-439

DEPOSITION OF DIANE SCHWARTZ
LAS VEGAS, NEVADA
VOLUME 1

REPORTED BY:
KENDALL D. HEATH
NEV. CCR NO. 475
CALIF. CSR NO. 11861
JOB NO.: 2959290
PAGES 1 - 163

Dr. Garvey before going to the hospital at the time frame we're talking about; correct?
A I did not know him.
Q Do you know if Doug knew him?
A I do not know if Doug knew him, but I would doubt it because he only been to the hospital the one other time.
Q I just ask, Elko I image it's a smaller community; right?
A Yeah. I didn't know very many people there, honestly.
Q Did you have any understanding as to Dr. Garvey's -- who his employer was at the time that you came to the hospital?
A I had no idea.
Q And I want to know if you had formed any belief about whether he was an employee of the hospital or if he was an employee of a practice group?
A I had no understanding at all other than -- I assumed he worked for the hospital because he was working in the E.R.
Q But you didn't have any information one way or the other as to who he worked for?
A No.

Q True?
A True, I had no idea.
Q So you hadn't formed any sort of opinion or belief at that time as to whether or not he was an employee of the hospital or employee of a practice group or some other?
MS. MORALES: Objection; misstates her testimony.
THE WITNESS: My understanding was he worked for the hospital because he was at the hospital working.
BY MR. DOBBS:
Q Do you recall when you arrived at the hospital, did you ever -- do you recall filling out paperwork?
A I know people brought me forms to sign regarding just your standard stuff.
Q And I think I have at least one of those forms. And I'm just going to show it to you real quick.
Do you recall what time frame that was that you were filling out the forms at the hospital?
A Probably within 30 or so minutes after we got there.
Q So that was early on in the admission;

right?
A Yes, yes.
Q What I handed you is, it's called a "Consent for Services and Financial Responsibility." You see that?
A Uh-huh.
Q At the bottom right-hand corner we've got Bates numbers. And the Bates numbers on this are the page numbers, and this one is NEN000030, and it goes through NEN40.
I just wanted to, if you could, turn to page 32 of that document. Right there.
A Uh-huh.
Q Before I go on, do you remember signing this record?
A No. Obviously I did, but ...
Q And you say obviously you did. Why do you say that?
A Because it's my signature, but I mean, you just sign papers when they bring them.
Q That's what I wanted to know. Is the signature on page 32, is that indeed your signature?
A Yes.
Q But you don't have a recollection of actually signing this document?

A Well, not really, but just, yeah, obviously.
Q You remember signing documents, but you don't remember specifically this record?
A And I don't remember specifically any of the what they were. I just signed them because they told me to.
Q You recall if you reviewed them?
A More than likely they probably just said a few things, and so I said okay.
Q If you could turn to page 31. If you look at paragraph 10, do you see that?
A Yes.
Q It says "Relationship between hospital and physicians, other healthcare providers." You see that?
A Yes.
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.
Q You pointed that out, yes.
My question is, this document is something that you signed at the hospital; correct?
A Yes.
Q And other than this record, you didn't have any information about Dr. Garvey's employment status; correct?
A I did not have any knowledge.
Q So this would have been the only record that you had within your possession at the time that had any indication about what Dr. Garvey's employment status could be; true?
MS. MORALES: Objection; form.
THE WITNESS: I had no idea.
BY MR. DOBBS:
Q But this is the only thing that would have indicated --
A As far as I know, this is the only thing I would have signed, but I didn't know it was there.
Q But Dr. Garvey, he didn't say to you --
A No. He did not say anything about that to me.
Q Earlier there was some, I believe you testified that Danny Benson mentioned to you that he

overheard somebody say something about a suction machine not working?
A Yes.
Q Do you recall when you had that conversation with Danny Benson?
A I do believe it was within the next day or two, because I had to go to the credit union or something, and he mentioned it to me, if I remember correctly. I think it was at the credit union.
Q And who was it again that he believed had told that to him?
A It was the friend that came out of the emergency room that said he was going to bring his daughter back.
Q And do you recall that friend's name? I don't know if you said it earlier or not.
A I don't remember. I did put it on the information, but I can't remember his name. Tony something, maybe.
Q So this was something that Danny Benson had heard from Tony, and then he was then telling you?
A Yes.
Q You didn't hear it firsthand; correct?
A I did not hear it firsthand.
Q And you didn't have any details about what he

meant as to whether they weren't able to get the suction or --
A I don't have any idea. All I know, he just told me that, which kind of sparked my interest as to, okay, what the heck happened in there?
Q And this was a couple of days after the hospitalization?
A Yeah, probably.
Q So you didn't have any conversations regarding a suction machine not working at the time you were at the hospital?
A No.
Q Is that true?
A And still don't know if that is even true.
Q But you didn't have any conversations, correct, at the hospital?
A No.
Q Is that correct? It's a double negative.
A Yeah.
Q I guess I should ask you, did you have any conversations at the hospital regarding --
A No, I did not. And I have not read that in anything. I do not know if that's even the case --
Q Okay.
A -- and I didn't believe it just because he

said it; I just heard that.
Q Okay.
A But I did want to find out if that was true.
Q Did you do anything to find out?
A No. I read through the records, but not looking specifically for that, just ...
Q And I think we've discussed several of the conversations you had with Danny Benson about what the administration clerk or whoever it was said about filing a lawsuit; correct?
A What are you asking me?
Q Do you remember that conversation?
A Yes, but I'm not sure what you're asking me.
Q Let me get there. Are there any criticisms -- strike that.
Besides your conversations with Danny Benson, did you have any discussions with any hospital staff members that you understood to be a criticism of the treatment that your husband received?
A No, other than the nurse that contacted Marie, but I didn't speak with her myself. They were all very helpful that night.
Q The staff members?
A Yes.

EXHIBIT 11 submitted to the Court under seal

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 I through X; ROE BUSINESS ENTITIES XI through XX, inclusive, Defendants.	Case No.: CV-C-17-439 Dept. No: 1 **EXHIBIT 11 TO PLAINTIFF'S OPPOSITION TO PHC-ELKO, INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL'S MOTION FOR PARTIAL SUMMARY JUDGMENT** **SUBMITTED UNDER SEAL**

CLAGGETT & SYKES LAW FIRM

EXCLUSIVE PROFESSIONAL SERVICES AGREEMENT

Attachment 32

Date of Agreement	January 26, 2015		
"Effective Date" See restriction in Section VI	February 10, 2015	"Initial Term" January 1, 2015 thru December 31, 2017	3 years
"Contractor"	Southeastern Emergency Physicians, LLC	"Hospital"	PHC-Elko, Inc. d/b/a Northeastern Nevada Regional Hospital
"Contractor Address"	265 Brookview Centre Way Suite 400 Knoxville, TN 37919 Attention: CEO	"Hospital Address"	2001 Errecart Boulevard Elko, NV 89801 Attention: CEO
"State"	Nevada		
"Initial Term Year 1 Total Annual Practice ED Subsidy Amount"	An amount as determined by allocation a share of total subsidy to the hospitals covered in the Master Agreement between LifePoint Corporate Services, General Partnership ("Company") and Southeastern Emergency Physicians, LLC, a Tennessee limited liability company ("Contractor").	Such allocation will be based on the relative cost of providing the services per the schedules checked below. Specific hospital's revenue and expense for the services provided will be considered in determining this allocation	

Years One (1) and Two (2) of the Attachment: Contractor's Annual Contribution Margin will not be considered in the calculations contemplated per Section V.A.2 of the Master Agreement.

Year Three (3) of the Attachment: Fifty Percent (50%) of Contractor's Annual Contribution Margin will not be considered in the calculations contemplated in Section V.A.2 of the Master Agreement.

Year Four (4), and every year thereafter, of the Attachment: One-hundred Percent (100%) of Contractor's Annual Contribution Margin will be considered in the calculations contemplated in Section V.A.2 of the Master Agreement.

In no case shall Hospital pay an Annual Practice Subsidy Amount or a Monthly Subsidy Payment during the first Four (4) years of the Term of this Attachment.

Terms of shared excess revenue/profits:	Per Master Agreement dated July 1, 2014 between LifePoint Corporate Services, General Partnership ("Company") and Southeastern Emergency Physicians, LLC, a Tennessee limited liability company ("Contractor").

The following checked Schedules are attached to and made a part of this Agreement:

	Schedule	Title
☒	1	Emergency Department Agreement
☐	2	Hospitalist Agreement

IN WITNESS WHEREOF, Hospital and Contractor have duly executed this Agreement as of the dates set out beneath their respective signatures.

The undersigned hereby certifies that:

1. I have reviewed the Agreement described above;
2. The compensation arrangement is established at fair market value for the services to be rendered;
3. The Agreement covers all of the services to be provided by the Contractor; and
4. There are no agreements or understandings, whether written or oral, that condition the compensation on the volume or value of any referrals or other business generated between the Parties.
5. I will verify that the required services are rendered prior to payment.

CONTRACTOR:

Southeastern Emergency Physicians, LLC

By: John H Proctor MD

Name: John H Proctor MD

Title: President

Date: 1/30/15

HOSPITAL:

PHC-Elko, Inc. d/b/a Northeastern Nevada Regional Hospital

By: Nicle Palagi

Name: Nicle Palagi

Title: CEO

Date: 2.10.15

Effective: 04.18.12
Revised:

This Exclusive Professional Services Agreement (the "Agreement") is hereby entered into by and between Hospital and Contractor who may hereafter be referred to individually as a "Party" and collectively as the "Parties" in connection with the Exclusive Emergency Department and Hospitalist Services Master Agreement (the "Master Agreement") dated the 1st day of January, 2015, by and between LifePoint Corporate Services, General Partnership ("Company") and Contractor.

RECITALS

WHEREAS, Hospital has determined that coverage by an exclusive group of providers based at Hospital is necessary to meet the needs of patients at Hospital; and

WHEREAS, Hospital has determined that the proper, orderly and efficient delivery of such services at the Hospital (the "Services") can be accomplished best by entering into an exclusive coverage arrangement; and

WHEREAS, Contractor will, at its expense, arrange coverage for Hospital through licensed physicians (individually referred to as "Physician" and collectively referred to as "Physicians"), and certified nurse practitioners or physician assistants (individually referred to as "Allied Health Practitioner" and collectively referred to as "Allied Health Practitioners") (Physicians and Allied Health Practitioners collectively referred to as "Contractor's Representatives") authorized and licensed to practice medicine where Hospital is located (the "State"), who are qualified to provide the services as defined in this Agreement; and

WHEREAS, Hospital desires to contract with Contractor as set forth herein to obtain management services of Contractor with respect to the professional component of services provided at the Hospitals so as to permit the development and operation of certain departments at Hospital; and

WHEREAS, this Agreement is entered into for the purpose of defining the Parties' respective rights and responsibilities; and

WHEREAS, the terms of the Master Agreement are incorporated herein as though fully repeated verbatim.

NOW, THEREFORE, in consideration of the premises and mutual covenants and agreements herein set forth, the Parties hereto agree as follows:

I. OBLIGATIONS OF CONTRACTOR

A. Organization. Contractor represents and warrants that it is a corporation or limited liability company duly organized and validly existing under the laws of its state of incorporation and has the corporate power and authority to execute and deliver this Agreement, and to carry out its provisions.

B. Services. Contractor shall (through appropriately licensed Contractor's Representatives) provide professional services needed at the Hospital, including but not limited to those services described as set forth in any attachment(s) defined as Professional Service Agreement(s) (the "Services") attached hereto.

C. Professional Qualifications. Contractor shall ensure that all Contractor's Representatives utilized to provide Services under this Agreement continuously have and maintain the following credentials:

1. Contractor's Representatives will be qualified by training and experience to provide the Services; and

2. The Contractor's Representatives assigned to Hospital shall have the Medical Staff or allied health privileges required to provide Services under this Agreement in accordance with the applicable requirements and Medical Staff bylaws, and each of Contractor's Representatives shall comply with Hospital policies and procedures, Medical Staff bylaws, and rules and regulations for Hospital.

D. Approval of Contractor's Representatives and Substitutes.

1. Contractor agrees it shall not use any Physician or Allied Health Professional to provide the Services under this Agreement to Hospital without first obtaining appropriate medical staff or allied health privileges and 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.

2. Contractor shall provide a substitute for any of Contractor's Representatives who are unable to provide services required under this Agreement. As a condition of providing services under this Agreement, any such substitute shall satisfy all qualification requirements applicable to the Contractor's Representatives.

3. Contractor agrees to cause each of Contractor's Representatives and substitutes to comply with his or her assigned Hospital policies and procedures, Medical Staff bylaws and rules and regulations. Failure to do so shall be grounds for Hospital to request Contractor to immediately remove the Contractor's Representative or substitute as described under Section II below. Hospital shall supply a copy of its Medical Staff Bylaws to Contractor within thirty (30) days of execution of this Agreement (if not already supplied), and shall supply an updated version upon any revision.

E. Compliance.

1. Contractor and Contractor's Representatives shall perform all Services under this Agreement in accordance with any and all regulatory and accreditation standards applicable to Hospital and the Services, including, without limitation, those requirements imposed by the Medicare Conditions of Participation, The Joint Commission accreditation standards, the AMA Code of Ethics, the rules and regulations of the Board of Medicine in the State, the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Federal Anti-Kickback and Stark statutes and regulations, federal and state regulations governing the security and privacy of health information, and other applicable state and federal regulations, all as amended from time to time.

2. Contractor represents and warrants that as of the date of this Agreement: (i) neither it nor any Contractor's Representative is excluded, debarred or otherwise ineligible to participate in Medicare, Medicaid or any other federal or state healthcare programs or in any federal or state procurement or non-procurement programs; and (ii) neither it nor any Contractor's Representative has been convicted of a criminal offense that could lead to such debarment or exclusion. Contractor shall immediately remove from service hereunder any Contractor's Representative for whom this representation and warranty is no longer true and shall so inform the Hospital to which Contractor's Representative is assigned. In the event this representation and warranty becomes untrue as to Contractor, Hospital may deem this Agreement terminated immediately. Contractor agrees this is an ongoing representation and will immediately notify Hospital in the event the foregoing representation and warranty is no longer completely accurate. Contractor acknowledges and agrees this is a material term of the Agreement and any breach or nonfulfillment of same will entitle the Hospital to terminate this Agreement immediately.

F. Quality Programs. Contractor and Contractor's Representatives shall furnish any and all information, records and other documents related to Contractor's service at the Hospital, which Hospital may reasonably request in furtherance of quality assurance, utilization review, risk management, and any other plans and/or programs adopted by Hospital to assess and improve the quality and efficiency of the Hospital's services. As reasonably requested, Contractor and Contractor's Representatives shall participate in one or more of such plans and/or programs, including participating in training on any such program at Hospital's request.

G. Medical Records for All Patients Evaluated and/or Treated by Contractor's Representatives. Unless otherwise specifically agreed to by the Parties, all patients evaluated and/or treated by Contractor's Representatives shall have a medical record created and a charge assigned, including all direct admissions undertaken by Contractor's Representatives. Contractor shall prepare timely, complete and accurate medical records in accordance with Hospital's policies and all professional standards applicable to medical records documentation. All such records shall be entered into Hospital's medical records system, including full use of Computerized Physician Order Entry. Medical records for patients evaluated and/or treated by Contractor's Representatives in Hospital shall at all times remain the property of Hospital.

II. **REMOVAL OF PHYSICIANS PROVIDED BY CONTRACTOR.** Contractor's Representatives shall be removed at the request of Hospital to which such Contractor's Representative is assigned, as follows:

A. For Cause. Upon Hospital's written notice to Contractor to remove any of Contractor's Representatives for cause, Contractor shall remove Contractor's Representative immediately from providing services under this Agreement. In that event, Contractor shall immediately provide a replacement for Contractor's Representative. For cause removals may include, but are not limited to, a Contractor's Representative who: (1) is convicted of a crime other than a minor traffic violation, (2) has a guardian or trustee of its person or estate appointed by a court of competent jurisdiction, (3) becomes disabled so as to be unable to perform the duties required by this Agreement, (4) fails to maintain professional liability insurance required by this Agreement, (5) has his/her license(s) and/or privileges required to perform the services

contemplated by this Agreement either suspended, revoked or otherwise limited, (6) is debarred, sanctioned or excluded by a state or federal health care program, or (7) fails to comply with any of the terms and conditions of this Agreement after being given notice of that failure and a reasonable opportunity to comply. Failure of Contractor to remove Contractor's Representative shall be deemed a material breach of this Agreement and Hospital may immediately terminate this Agreement.

B. Effect on Contractor's Representatives Medical Staff Appointment and Clinical Privileges. Because this is an exclusive Agreement, as more particularly described in Section IV, the medical staff appointment and clinical privileges of all Contractor's Representatives providing services to Hospital shall be incident to and coterminous with this Agreement, and, upon termination or expiration of this Agreement or upon removal of Contractor's Representative by Contractor, the appointment and clinical privileges of the Contractor's Representative shall automatically terminate except as otherwise provided below. Notwithstanding the foregoing, a Contractor Representative's Medical Staff Appointment and Clinical Privileges will not automatically terminate upon termination or expiration of this Agreement unless a continuation of such privileges, in Hospital's reasonable judgment, would be inconsistent with Hospital's ability to contract exclusively with a successor provider of Services. Any rights that the Contractor's Representatives may have to any hearing or appeal procedures prior to termination of Medical Staff Appointment or Clinical Privileges, pursuant to the bylaws or policies of a Hospital or its Medical Staff, or any other state or federal statute, regulation or judicial decision are hereby waived with respect to any termination of Medical Staff Appointment or Clinical Privileges resulting from the items listed herein. Unless otherwise required by law, no reporting to any third party, such as the National Practitioner Data Bank, shall take place for any termination hereunder for non-clinical or non-competency issues. Contractor will require each Contractor's Representative providing Services under this Agreement to execute a separate Contractor Representative Agreement Regarding Medical Staff Membership and Privileges in substantially the same form as ADDENDUM 1, attached hereto and incorporated by reference into this Agreement. If Contractor has a substantially similar provision in its contracts with its Physician and Allied Health Practitioners, Contractor will not be required to comply with the requirement in the foregoing sentence.

III. OBLIGATIONS OF HOSPITALS

A. Hospital Billing. Hospital shall be responsible for, and solely entitled to, billing and collection of all Hospital services rendered to the patients to whom the Services are provided and non-physician provider services performed for the general benefit of its patients, except those for professional services rendered by Contractor's Representatives who are either contracting with or employed by Contractor.

B. Supplies, Equipment, Etc. Hospital will make available the space, utilities, equipment, supplies (to include drugs and narcotics) and services (including housekeeping and laundry) reasonably necessary for the proper operation of the Services. Hospital will maintain its equipment in good order and repair.

C. Facilities and Personnel. Hospital shall provide adequate facilities and competent personnel for the operation of the Services. Hospital shall provide other reasonable support services necessary for proper operation of the Services (including scheduling non-Contractor's Representative personnel, preparing and filing of patient treatment consents and providing other services which are reasonable and mutually agreed upon). Hospital shall provide an adequate medical records system for use in provision of the Services.

D. Transcription. Hospital will provide appropriate dictation, transcription, and medical record services to Contractor for use by Contractor's Representatives for documentation made by Contractor's Representatives in Hospital medical record.

E. Medical Staff On Call. Hospital shall have available specialty physicians on-call in accordance with its Medical Staff bylaws.

F. Materials to Patients. Hospital will, in good faith, attempt to distribute to patients to whom the Services are provided materials describing the separate billing relationship between the patients and Contractor. Such materials will be supplied to Hospital by Contractor on a form acceptable to Hospital.

G. Compliance. Hospital represents and warrants that as of the date of this Agreement: (i) Hospital is not excluded, debarred or otherwise ineligible to participate in Medicare, Medicaid or any other federal or state healthcare programs or in any federal or state procurement or non-procurement programs; and (ii) Hospital has not been convicted of a criminal offense that could lead to such debarment or exclusion. In the event this representation and warranty becomes untrue as

to Hospital, Contractor may deem this Agreement terminated immediately. Hospital agrees this is an ongoing representation and will immediately notify Contractor in the event the foregoing representation and warranty is no longer completely accurate. Hospital acknowledges and agrees this is a material term of the Agreement and any breach or nonfulfillment of same will entitle the Contractor to terminate this Agreement immediately.

H. Billing Information. Hospital shall supply Contractor with information necessary for Contractor to bill patients for services rendered by the Contractor's Representatives. In order to allow Contractor to accurately and timely bill for professional services provided by Contractor Representatives hereunder, Hospital agrees to provide Contractor, with either: (i) an electronic file transfer containing patient medical records and related information, including, but not limited to, physician transcription, physician notes, insurance cards and demographic information necessary to conduct physician billing ("Billing Documents"), or (ii) the requested assistance necessary to obtain legible paper copies of Billing Documents to forward to Contractor, which assistance shall include, but not be limited to:

1. Hospital will locate any missing Department records and forward such missing records to Contractor within three (3) working days.

2. Hospital will use commercially reasonable efforts to arrange for patient signatures on forms noting patient's responsibility for paying Contractor's billings.

3. Hospital shall bear the expense of providing one copy of relevant patient medical records to be sent to Contractor.

4. Hospital will comply within three (3) working days with other reasonable requests for information or record handling (including requests regarding insurance) by Contractor.

In the event Hospital has implemented an Electronic Medical Records ("EMR"), Contractor will electronically transmit Billing Documents from Hospital to Contractor. In such event, Hospital will work cooperatively with Contractor and Contractor's Information Technology department to facilitate the timely and accurate flow of Billing Documents to Contractor. This information will be transmitted from Hospital to Contractor in a secure HIPAA compliant electronic format on a daily basis. The Billing Documents transmitted in this fashion will include, but not be limited to: ADT Registration information (patient demographics, payor information, and disposition), event times, and to the extent possible patient clinical record.

Each Hospital shall assist Contractor in obtaining patient signatures on assignment of insurance benefits and other reasonably appropriate forms supplied to the respective Hospital by Contractor. Any collection efforts by the Hospitals and Contractor will comply with all federal and state laws and regulations.

IV. EXCLUSIVITY

A. Hospital concludes that an exclusive relationship for the Services will best facilitate the delivery of efficient, effective and quality patient care. Such a relationship is expected to enhance patient services provided by Contractor and the Hospital, improve the relationships between Contractor, the Hospital's Medical Staffs and Hospital, afford effective utilization of the Hospital's equipment, provide consistent service and quality control, provide prompt availability of professional services, simplify scheduling of patients and physician coverage, enhance the efficient and effective administration of the Services – all of which enhance the quality of patient care.

B. During the term of this Agreement, Contractor shall be the exclusive provider of the Services described in this Agreement, and therefore, Hospital will ensure does not extend medical staff privileges for the practice of the Services at Hospital to any provider not employed by or under contract with Contractor. However, nothing in the preceding sentence shall be construed to limit the rights of community-based physicians with medical staff privileges at the Hospital to provide care for their patients while they are admitted to the same.

V. TERM AND TERMINATION

A. This Agreement shall be effective as of the Effective Date, beginning at 12:00 a.m. in the applicable time zone of the Hospital and shall continue for the Initial Term. [**NOTE: The Effective Date cannot be a date that occurs before the dates that both the Hospital and Contractor signed the Agreement. If the Agreement is submitted for approval with an Effective Date that occurs before the last party (The Hospital or Contractor) signed the Agreement, the Effective Date will automatically be changed to the date that the Contractor or Hospital**

signed, whichever is later. Contractor will not be compensated for services provided to the Hospital prior to the Effective Date.] Notwithstanding the foregoing, this Agreement will automatically renew for additional twelve (12) month periods following the expiration of the Initial Term, with each such additional twelve (12) month period to be called an "Additional Term", until (i) such time as a new Agreement is executed by the Parties, or (ii) this Agreement is otherwise terminated as provided herein.

B. Notwithstanding anything herein to the contrary, either Party may terminate this Agreement, without cause by providing not less than one hundred eighty (180) days prior written notice stating the intended date of termination. In the event the Parties terminate this Agreement prior to the first annual anniversary of the Effective Date the Parties agree they will not enter into a new agreement for the same or similar services prior to the first annual anniversary of the Effective Date.

C. Either Party may terminate this Agreement at any time in the event the other Party engages in an act or omission constituting a material breach of any term or condition of this Agreement. The Party electing to terminate this Agreement shall provide the breaching Party with written notice specifying the nature of the breach. If a dispute arises regarding the materiality of a breach, then both Parties shall submit the issue to a mutually agreed upon arbitrator pursuant to Section VIII of this Agreement for resolution of the dispute. The breaching Party shall then have twenty (20) days from the date of the notice or twenty (20) days from the date of the arbitrator's decision in which to remedy the breach and conform its conduct to this Agreement. If such corrective action is not taken within the time specified, this Agreement shall terminate at the end of the twenty (20) day period without further notice or demand, provided, however, that Hospital may not terminate this Agreement if Contractor is diligently pursuing the remedy of the breach.

D. Either Party may terminate this Agreement immediately as specified in Sections I.E.2 and III.G. of this Agreement.

E. Either Party may terminate this Agreement immediately if either Party makes a general assignment for the benefit of creditors, or files a petition for relief in bankruptcy or under similar laws for the protection of debtors, or upon the initiation of such proceedings against either Party if the same are not dismissed within forty-five (45) days of service;

F. Either Party may terminate this Agreement immediately if any of the following events occur with regard to Hospital:

1. Loss of Hospital's certification as a Medicare provider;

2. Closure of Hospital;

3. Contractor's general assignment for the benefit of creditors, Contractor's petition for relief in bankruptcy or under similar laws for the protection of debtors, or upon the initiation of such proceedings against Contractor if the same are not dismissed within forty-five (45) days of service; or

4. Hospital's general assignment for the benefit of creditors, or Hospital's petition for relief in bankruptcy or under similar laws for the protection of debtors, or upon the initiation of such proceedings against Hospital if the same are not dismissed within forty-five (45) days of service; or

5. Starting January 1, 2015, Contractor's failure to achieve an overall minimum score of 60 points on the "ED Physician Scorecard" or "Hospitalist Physician Scorecard", if applicable (as may be further defined in this Agreement) at Hospital for any two consecutive quarters during the term of this Agreement or any renewal period thereof. Contractor, however, shall have the right, at its own expense, to review and audit any performance metric contained in the ED Physician Scorecard or Hospitalist Physician Scorecard, including all underlying data. Hospital agrees to resolve any discrepancy found during an audit performed by Contractor to the Parties' mutual satisfaction. If a dispute arises or the Parties are unable to resolve the discrepancy to their mutual satisfaction, then both Parties shall submit the issue to a mutually agreed upon arbitrator pursuant to Section VIII of this Agreement for resolution of the dispute.

G. Except as provided herein, upon any termination of this Agreement, neither Party shall have further rights against, or obligations to, the other Party except with respect to any rights or obligations accruing prior to the date and time of termination and any obligations, promises or agreements which expressly extend beyond the termination, including but not limited to the terms herein related to insurance coverage, restrictive covenants, dispute resolution and confidentiality provisions. Contractor shall have reasonable access to any Hospital's information and records pursuant to Section III (H) of the Agreement for a period of six months after termination of this Agreement for Contractor's billing, risk management and/or quality/peer review purposes.

VI. RISK MANAGEMENT

A. Required Risk Reduction Education. As fair market value consideration, Hospital may reimburse or pay all actual expenses associated with the costs of any educational sessions related to the Service that Contractor and/or Contractor's Representatives are directed to attend by Hospital. All such expenses must be reasonable, and the Contractor and/or Contractor's Representatives must be authorized in advance, and in writing by the Hospital's CEO, to incur such expenses, and such expenses must be paid in accordance with Hospital's policies and procedures. All such expenses are limited to those incurred by Contractor and/or Contractor's Representatives only (e.g., expenses of spouses and other family members are excluded from reimbursement).

B. Provision of Services for Risk Management or Employment Purposes of Hospital. Contractor agrees to provide Services as requested by Hospital in response to risk management issues or employee health efforts of Hospital. In these situations, if requested by Hospital to waive Contractor's fees after the Services have been provided, Contractor shall bill the Hospital for its professional charges rather than the patient or the patient's insurance plan. Contractor agrees to accept the then current year Medicare Physician Fee Schedule reimbursement amount, or where applicable, state workers' compensation amounts, for any such services rendered.

VII. ALTERNATIVE DISPUTE RESOLUTION. The Parties firmly desire to resolve all disputes arising hereunder without resort to litigation in order to protect their respective business reputations and the confidential nature of certain aspects of their relationship. Accordingly, any controversy or claim arising out of or relating to this Agreement shall be settled by arbitration administered by the American Health Lawyers Association in accordance with its rules. The award or decision rendered by the arbitrator will be final, binding and conclusive, and judgment may be entered upon such award by any court of competent jurisdiction. The arbitration process itself, and any other information or disclosures revealed by either Party to the arbitrator or to the other Party during the arbitration process will be confidential. No disclosure of the award shall be made by the Parties except as required by the law or as necessary or appropriate to effectuate the terms thereof. The location of the arbitration shall be in a city mutually agreeable to the Parties. The dispute shall be governed by the laws of the State. Further, the prevailing Party shall be entitled to recover all costs and expenses associated with arbitration, including reasonable attorneys' fees. If the arbitrator determines that neither Party has substantially prevailed, the Parties shall bear equally the fees and costs of the arbitrator and the related expense of arbitration.

VIII. PARTIES' RELATIONSHIP. The Parties acknowledge that Contractor is an independent contractor to Hospital for the furnishing of Contractor's Representatives who agree to render Services to patients of the Hospital. Neither Contractor nor Contractor's Representatives shall in any way be construed as employees of any of the Hospital. Neither Contractor nor any of its agents (employees or contractors) shall have the right or authority to enter into any contract in the name of the Hospital or otherwise bind the Hospital in any way without the express written consent of the Hospital designee.

IX. PERFORMANCE DATA. Hospital agrees to comply with Contractor's reasonable request for financial and performance data related to utilization at Hospital. Contractor shall make such requests no more than quarterly during the term of this Agreement.

X. INSURANCE AND INDEMNIFICATION.

A. Contractor hereby agrees to indemnify and hold harmless Hospital and Hospital's officers, directors, employees, agents, successors and assigns from and against any claim, damage, loss, expense, liability, obligation, action or cause of action, including reasonable attorneys' fees and reasonable costs of investigation, which Hospital or Hospital may sustain, pay, suffer or incur by reason of any negligent act or omission of Contractor, if applicable, in connection with services provided and duties undertaken under this Agreement, including any claims for personal injury or wrongful death. To ensure coverage in the event of an act or omission as described above, Contractor shall (i) maintain in force at all pertinent times at its sole expense a policy of general and professional liability insurance in the minimum amount of $ 1 million per occurrence, $ 3 million in the annual aggregate, naming Hospital as an additional insured thereon, or such higher amount as may be required by the laws of the State; and (ii) if applicable, participate in the appropriate state compensation fund. Contractor shall furnish, at Hospital's request, a Certificate of Insurance evidencing the aforementioned coverage.

B. Hospital hereby agrees to indemnify and hold harmless Contractor from and against any claim, damage, loss, expense, liability, obligation, action or cause of action, including reasonable attorneys' fees and reasonable costs of investigation, which Contractor may sustain, pay, suffer or incur by reason of any negligent act or omission of Hospital, its agents or

employees in connection with services provided and duties undertaken under this Agreement, including any claims for personal injury or wrongful death.

C. Contractor and Hospital each agree and it is the stated intent of each that they shall only be liable to the other party under this Section for the proportionate liability or representative share of negligence allocated to such party based on the negligent acts or omissions of each party. If such allocation is not determined by a court of competent jurisdiction and the parties in good faith are otherwise unable to agree to such allocations, either party hereto may bring an action, including a summary or expedited proceeding, to compel binding arbitration of such matter.

XI. **ACCESS TO BOOKS AND RECORDS.** In the event it is held that Section 1861(v)(1)(1) of the Social Security Act is applicable to this Agreement, it is agreed:

A. Until expiration of five (5) years after furnishing services and pursuant to this Agreement, Contractor shall make available upon written request of the Secretary of Health and Human Services or the U.S. Comptroller General, or any of their duly authorized representatives, this Agreement, books, documents, and records of Contractor that are necessary to verify the nature and extent of costs incurred by Hospital under this Agreement.

B. If Contractor carries out any of the duties of this Agreement through a subcontract with a related organization with a value of Ten Thousand Dollars ($10,000) or more over a twelve (12) month period, such agreement must contain a clause to the effect that until the expiration of five (5) years after the furnishing of services under the subcontract, the related organization shall make available, upon written request of the Secretary of Health and Human Services, the U.S. Comptroller General, or any of their duly authorized representatives, the subcontract, any books, documents, and records of the related organization that are necessary to verify the nature and extent of costs incurred by Hospital under this subcontract.

C. In the event said sections are found to be inapplicable to this Agreement, this article shall be deemed not to be a part of this Agreement and shall be null and void with respect thereto.

XII. **NOTICES.** Any notice required or permitted to be given hereunder shall be in writing and may be given by: (1) hand delivery and shall be deemed given on the date of delivery; (2) registered or certified mail and shall be deemed given the third day following the date of mailing; or (3) overnight delivery by reputable overnight delivery service such as Federal Express or UPS and shall be deemed given the following day. All notices to Contractor or Hospital shall be addressed to Contractor or Hospital at the addresses as set forth on the signature page, together with a required copy to: LifePoint Hospitals, 330 Seven Springs Way, Brentwood, TN 37027, Attention: Chief Legal Officer.

XIII. **CONFIDENTIALITY.** The Parties agree that this Agreement and its provisions are strictly confidential. The Parties shall not disclose any information pertaining to any provision of this Agreement to any person or entity not a party to this Agreement except for tax, legal, or accounting advisors or as otherwise required by law.

XIV. **VENDOR PROMOTION/PUBLICATION.** Hospital prohibits the use of Hospital's name by any vendor or independent contractor, or the use of any name of Hospital's subsidiaries, or affiliated hospitals in any advertisement, press statement or release, website, published customer list, or any publication or dissemination similar to the foregoing without receiving in advance the express written permission from Hospital's Chief Executive Officer or his or her designee. Any request for permission should include the complete text of the publication, statement, or document in which the name usage will appear and will be subject to edit by the Hospital.

XV. **MARKETING SERVICES/COMPENSATION OF CONTRACTOR'S REPRESENTATIVES.** Except as specifically provided in this Agreement, Contractor shall not perform and is not being compensated for marketing services with respect to the Services to be performed at the Hospital. Contractor represents and warrants that no part of the compensation paid hereunder is in exchange for the referral or arrangement for referral of any patient to of Hospital. Contractor represents and warrants that, in connection with the Services to be performed pursuant to this Agreement, each employee, independent contractor, or other entity or person performing Services pursuant to the Agreement shall be compensated in a manner that complies with the Federal Anti-Kickback Statute, an exception to the Stark law, and as applicable, an appropriate exception to any state statutes similar to either or both of the foregoing federal statutes.

XVI. **SEVERABILITY.** The invalidity or unenforceability of any provision(s) of this Agreement will not affect the validity or enforceability of any other provision(s).

XVII. **NO WAIVER.** No waiver of a breach of any provision of this Agreement shall be construed to be a waiver of any breach of any other provision.

XVIII. **ASSIGNABILITY.** Contractor may not assign any of its rights or obligations hereunder without the prior written consent of Hospital, which consent will not be unreasonably withheld. Hospital may not assign this Agreement to any successor to all or substantially all of Hospital's operating assets without the prior written consent of Contractor, which consent will not be unreasonably withheld. This Agreement shall inure to the benefit of and be binding upon the Parties hereto and their respective successors and permitted assigns.

XIX. **NAME OR OWNERSHIP CHANGE.** This Agreement shall continue in full force and effect in the event of a change in the name or ownership Hospital or the Contractor.

XX. **AMENDMENTS.** Amendments to this Agreement shall be made only in writing duly executed by both Parties hereto.

XXI. **ENTIRE AGREEMENT.** This Agreement constitutes the entire agreement of the Parties with respect to the subject matter hereof, and supersedes all prior agreements, contracts and understandings, oral, written or otherwise, including but not limited to any prior agreements between Contractor and/or its affiliates and Hospital.

XXII. **THIRD PARTY BENEFICIARIES.** This Agreement is intended to, and shall be deemed and construed to create rights and/or remedies for the Hospitals, which shall be deemed third party beneficiaries to this Agreement.

XXIII. **AGREEMENT CROSS-REFERENCE.** As required by 42 C.F.R. section 411.357 (d)(1)(ii), all service agreements between Company or its affiliated Hospitals and any physician (or an immediate family member of a physician) are maintained electronically in a master contract database that is maintained and updated centrally and is available for review upon request by an authorized government official.

Contractor Representative Agreement Regarding Medical Staff Membership and Privileges

The undersigned hereby acknowledge and agrees that:

1. The undersigned is a Physician who may provide services to Hospital pursuant to Agreement between Hospital and Contractor.

2. Pursuant to the Agreement, Hospital has certain rights of approval over Physicians and others who provide services, and that; in addition, Hospital may request removal of a Physician or other provider of services under the Agreement. The undersigned understands that this will mean that Hospital may refuse to permit the undersigned to provide services under the Agreement, or request that the undersigned be removed from the permitted list of individuals providing services under the Agreement.

3. The undersigned agrees to the following: the medical staff appointment and clinical privileges of all Physicians and practitioners providing services under the Agreement shall be incident to and coterminous with the Agreement, and upon termination or expiration of the Agreement or upon removal of any Physician or practitioner by Contractor (independently or at Hospital's request) or Hospital's refusal to permit a Physician or practitioner to perform services under the Agreement, the appointment and clinical privileges of such Physician or practitioner shall automatically terminate except as otherwise provided below. Notwithstanding the foregoing, a Contractor Representative's Medical Staff Appointment and Clinical Privileges will not automatically terminate upon termination or expiration of the Agreement unless a continuation of such privileges, in Hospital's reasonable judgment, would be inconsistent with Hospital's ability to exclusively contract with a successor provider of emergency services. Any rights that the Physician or practitioner may have to any hearing or appeal procedures prior to termination of medical staff appointment or clinical privileges, pursuant to the bylaws or policies of Hospital or the Medical Staff, or any other state or federal statute, regulation or judicial decision, are hereby waived with respect to any termination of Medical Staff Appointment or Clinical Privileges at Hospital as described herein. Unless otherwise required by law, no reporting to any third party, such as the National Practitioner Data Bank, shall take place for any termination hereunder for non-clinical or non-competency issues.

ACKNOWLEDGED AND AGREED:

PHYSICIAN:

Signature: _____

Name: _____

Date: _____

CONTRACTOR:

Signature: _____

Name: _____

Title: _____

Date: _____

TERMS AND CONDITIONS

This Schedule 1 ("Schedule 1") is attached to and made a part of the Agreement. Definitions contained herein shall have the same meaning as contained in the Agreement. Should a conflict arise between the terms contained in the Agreement and this Schedule 1, then the terms of this Schedule 1 shall control.

Contractor will be responsible for carrying out the duties identified throughout this Schedule 1 and, additionally, the duties defined hereunder (collectively referred to as the "Services"), plus any Schedules identified below, each of which constitute an integral part of this Agreement:

SCHEDULE	TITLE
1.A	Services, Coverage, and Quality Criteria
1.B	Scorecard

I. **DESCRIPTION OF SERVICES.** Hospital is engaging the services of Contractor to enter into an exclusive relationship for professional Emergency Department ("ED") services which will best facilitate efficient, effective and quality emergency medical care for patients presenting to Hospital's ED. This engagement is expected to improve the services provided at the Hospital; afford effective utilization of the Hospital's equipment and resources, provide consistent service and quality control; provide prompt availability of professional services; simplify scheduling of physician coverage, and enhance the efficient and effective administration of ED services. Contractor and Contractor's Representatives shall practice within Hospital, assuming the role of ED physician or physician extender for patients presenting to Hospital emergency department ("Program Patients"). Allied Health Practitioners, if and when utilized, shall assist Contractor with their duties and responsibilities. Contractor shall provide to Program Patients all professional emergency medicine services that are medically necessary and within the capabilities of the Contractor's Representatives. Contractor's Representatives shall not be responsible for a Program Patient's care after discharge or admission, provided however, Contractor's Representatives shall participate in the Code Team utilized at Hospital, including responses to codes and to other emergency situations involving Program Patients admitted to Hospital.

A. DUTIES OF CONTRACTOR. In addition to the coverage requirements referenced above, Hospital and Contractor agree that the following shall be required duties of Contractor with respect to the Service:

1. Drive performance and be accountable to ED Service line initiatives around quality, service, throughput and growth in coordination with Hospital.
2. Participate in all quality programs outlined by Hospital that improve patient outcomes; Improvement in Value Based Purchasing metrics including but not limited to: core measures, mortality, HCAHPS, readmissions, Medicare Spending Per Beneficiary, and other quality outcome measures.
3. Participate in development and execution of programs and/or educational programs related to service for medical personnel at Hospital, including but not limited to ED Nursing Staff and other Hospital staff, students, interns, residents, as well as Contractor's employees, subcontractors and agents.
4. Must comply with EMTALA, CMS, The Joint Commission and all regulatory agency rules and regulations.
5. Assist and participate in educating the community and creating awareness around services, as requested.
6. Provide the following program enhancement services:

    a. Participate in development and implementation of evidence-based care guidelines that are consistent with local and national standards.
    b. Lead and drive quality improvement in coordination with ED Nurse Director and appropriate Hospital personnel to ensure appropriate care by all of Contractor's Representatives.
    c. In coordination with ED service line initiatives, lead, support and drive improvement through implementation of best practices to drive improved patient outcomes around quality, service and throughput.
    d. Engage and be accountable to quality assurance and improvement initiatives by attending meetings, leading committees, measuring results and holding those accountable to established goals and objectives.
    e. Select a designee for Hospital to meet on a monthly basis with the medical director, case manager, Hospital administration, ED nurse director, and key medical staff leaders i.e. hospitalist, and other individuals necessary to provide input on enhancements for the improvement of Services at Hospital.
    f. Must remain compliant with timely completion of medical records describing the results for all the medical services performed by Contractor's Representatives in ED.
    g. Provide onsite physician supervision for outpatient services rendered at Hospital in order to meet supervision requirements under Medicare.

7. Establish expectations and hold Medical Director and Contractors' Representatives accountable to establishing effective working relationships with ED Nurse Director and personnel, other departments, the Medical Staff, and the administration.
8. Contractor's Regional Medical Directors and Regional Nursing/Clinical Directors must meet with Hospital's ED Services Team at least quarterly to review program goals and objectives around performance related to quality, service, throughput and growth.

9. Contractors support service structure; i.e. customer service and performance improvement, etc., resources; must be accountable to and establish goals consistent with Hospital's ED Service Line priorities both on priority hospitals and metrics.
10. Contractor must use the physician scorecard, as established in Schedule 1.C, attached hereto and incorporated herein by reference, to align provider and Hospital objectives through a financial withhold in the Medical Director's contract.
11. Agree to work on related projects and perform such other related duties as mutually agreed upon by both parties.

B. DUTIES OF CONTRACTOR'S REPRESENTATIVES. Hospital and Contractor agree that the following shall be required duties of each of the Contractor's Representatives assigned to the Hospitals:

1. Must be consistent with Duties outlined in Section "A" above.
2. Provide emergency department medical treatment as needed for all patients presenting to the Hospital's emergency department.
3. Participate in the Code Team utilized at the Hospital, including responses to codes.
4. Consult with other Medical Staff physicians as needed to assist with evaluations, transfers, and/or admission of program patients or unassigned patients.
5. Meet all behavior and professional conduct requirements of the medical staff bylaws and rules of regulations.
6. Meet all other requirements of the medical staff bylaws, rules and regulations.
7. Complete appropriate documentation of patient medical records and signing of final medical record within required timeframes as required by the Medical Staff Bylaws and Rules and Regulations of Hospital.
8. Work cooperatively with all medical staff and Hospital personnel.

C. MEDICAL DIRECTOR. Contractor shall designate one physician to serve as the Medical Director ("Medical Director") of the Services for each Hospital.

D. The expectations and obligations for the Medical Director include:

1. In conjunction with the ED Nurse Director, drive performance and be accountable to the ED Service line initiative around quality, service, throughput and growth in coordination with the Hospital.
2. Lead and drive quality improvement in coordination with ED Nurse Director and appropriate Hospital personnel to ensure appropriate care by all providers in the ED.
3. In coordination with the ED service line initiative, lead, support and drive improvement through implementation of best practices to drive improved patient outcomes around quality, service and throughput.
4. Educate and hold the ED providers accountable to implement best practices supported by the Hospital around quality, throughput, service and growth and hold the ED providers accountable to meeting the goals and objectives (targets) established.
5. Engage and be accountable to quality assurance and improvement initiatives by attending meetings, leading committees, measuring results and holding those accountable to established goals and objectives (targets).
6. Serve as the professional liaison of the physicians associated with the emergency department program and work closely with Hospital and administration to solve program problems
7. Develop and implement programs to educate medical staff physicians across Hospital on the benefits of the Services to the patients and the community served by Hospital.
8. Establish a culture of safety by creating a professional atmosphere conducive to a high standard of patient care, investigate patient complains and incident reports, hold providers accountable to expectations, and provide high levels of service measured by ED patient Satisfaction.
9. Lead the monthly ED operations committee in coordination with the ED nurse director. The purpose of this multidisciplinary committee is to address key operational priorities around quality, service throughput and growth. The meetings should be data driven based on objective metrics that will drive improvement and patient outcomes in the emergency department.
10. Establish a close working relationship with the case manager of Hospital's emergency department program to ensure a high standard of patient care, proper patient care protocols are developed and maintained, coordinate work flow with the other ancillary departments within Hospital, and assist in the coordination of case management services.

11. Serve as an advisor to Hospital's quality improvement program.
12. In collaboration with the ED Nurse Director, revise existing policies and develop new policies as needed.
13. Participate in Hospital meetings, including but not limited to those related to performance improvement, quality improvement, patient experience, and utilization review.
14. Periodically review emergency department patient records to ensure the documentation, treatment, treatment plans, consults and tests ordered meet the appropriate standard of care.
15. Participate in the Hospital's peer review activities as requested/needed by Hospital.
16. Oversee the administration and management of Hospital's emergency department program and the Agreement with Hospital.
17. Ensure appropriate coverage for Hospital by scheduling coverage of the Services on a monthly basis, including on-site coverage.
18. Facilitate an evaluation process as it relates to the performance of all Contractor's Representatives that treat patients at Hospital. The performance evaluation may include input from other specialists who consult on patients presenting to Hospital's Emergency Department, Hospital personnel, etc. Performance shall be evaluated on the basis of professional attitude, professional capabilities, patient relations attitude and overall effectiveness as determined appropriate by Contractor and Hospital.

II. **COVERAGE.** In accordance with the terms of this Agreement, Contractor shall:

A. Ensure and deliver to Hospital continuous, twenty-four (24) hour on-site emergency medicine coverage, seven (7) days per week, fifty-two (52) weeks per year.

B. In order to provide the comprehensive coverage set forth above and meet patient needs, Contractor shall provide to Hospital a minimum number of qualified Physician coverage hours ("Qualified Physician Hours"), and if applicable, a minimum number of physician extender or Allied Health Practitioner coverage hours ("Allied Health Practitioner Hours).

Provider	Hours/day needed
Physician	24
NP/PA	12

C. Any adjustments to staffing requirements and hours of coverage other than those set forth in Section 2 above shall be agreed upon by Hospital and Contractor in writing.

D. In no event shall any Physician or Allied Health Practitioner providing services under the Agreement work more than twelve (12) consecutive hours in a twenty-four (24) hour period, unless prior advance written approval has been obtained from Hospital's Chief Executive Officer or his or her designee. Such advance written approval shall be waived in the case of a catastrophic event or extraordinary medical crisis.

III. **QUALITY CRITERIA.** Company and Contractor shall mutually agree upon an "ED Physician Scorecard" which shall be set forth in separate Attachments to this Agreement. Beginning January 1, 2015, Contractor shall cause Contractor's Representatives to meet the quality criteria set forth in the ED Physician Scorecard (the "Scorecard") for the Hospital, which shall be effective as of the date that the Scorecard is agreed upon by the Parties, which shall be no later than January 1, 2015. The agreed upon Scorecard shall be attached as Schedule 1.B, which may be amended from time to time by mutual agreement of the Parties. Any amendments to the Scorecard shall be implemented prior to the commencement of a new contract year, shall be based on the prior year's trends and achievements, and shall be mutually agreed upon. The Parties further agree to use their best commercially reasonable efforts to negotiate the Scorecard to be applicable hereunder within sixty (60) days of the Effective Date. Each of the quality criteria in the Scorecard will be monitored quarterly during the Agreement Term, and Hospital will deliver the results of such assessment to Contractor thirty (30) days from the assessed quarter end. The Parties acknowledge and agree that targets identified for each of the quality criteria meet only the minimum level of performance required from Contractor and Contractor's Representatives which shall be an annual overall score of sixty (60) points (the "Minimum Score").

ED PHYSICIAN SCORECARD - EMERGENCY DEPARTMENT - EXAMPLE ONLY

Points Possible (standard)	ED Provider Scorecard *Hospital Name* 2015	Group Name	Quarter 1		Quarter 2		Quarter 3	
		Goal	Results	Points Earned	Results	Points Earned	Results	Points Earned
	Delivering Compassionate Patient Care							
12.5	Patient overall rating of ED	Hosp Specific						
12.5	Patient overall rating of ED Providers	Hosp Specific						
25	**Total Points Earned**			0		0		0
	Delivering High Quality Patient Care							
15	ED Core Measure Performance	8/8						
15	Left Without Treatment (LPMSE + LPT)	<1.0%						
30	**Total Quality/Risk Points Earned**							
	Delivering Efficient Patient Care							
10	Arrival to MSE	Hosp Specific						
10	MSE to Disposition	Hosp Specific						
10	Overall Length Of Stay (Admitted)	Hosp Specific						
15	Overall Length Of Stay (Discharged)	Hosp Specific						
45	**Total Throughput Points**			0		0		0
100	Grand Total							

	Combined ED/Hospitalist Metric (Where Applicable)							
	HCAHPS	Hosp Specific						

Effective: 04 18 12
Revised

15

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Admitted Pro Hac Vice
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Nevada Bar No. 11953
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IN THE FOURTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA
IN AND FOR THE COUNTY OF ELKO

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

Plaintiff,

vs.

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

Defendants.

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

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

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

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

DATED this 7th day of October, 2021.

HALL PRANGLE & SCHOONVELD, LLC

By: /s/ Richard D. De Jong
JENNIFER RIES-BUNTAIN, ESQ.
Admitted Pro Hac Vice
TYSON J. DOBBS, ESQ.
Nevada Bar No. 11953
RICHARD D. DE JONG, ESQ.
Nevada Bar No. 15207
1140 North Town Center Drive, Ste. 350
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Attorneys for Defendant PHC-Elko, Inc., dba Northeastern Nevada Regional Hospital

DECLARATION OF RICHARD DE JONG, ESQ IN SUPPORT OF NORTHEASTERN NEVADA REGIONAL HOSPITAL'S MOTION FOR PARTIAL SUMMARY JUDGMENT

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

1. I am a duly licensed Nevada attorney and member of the bar of this Court practicing with the law firm of Hall Prangle & Schoonveld, LLC, at 1140 North Town Center Drive, Suite 350, Las Vegas, Nevada 89144, counsel of record for NORTHEASTERN NEVADA REGIONAL HOSPITAL.

2. Attached as Exhibit O is a true and accurate copy of the Minutes of the Assembly Committee on Medical Malpractice Issues, July 31, 2002.

3. Attached as Exhibit P is a true and accurate copy of the Deposition of Jonathan Burroughs.

4. Attached as Exhibit Q is a true and accurate copy of the Deposition of Barry Bartlett.

5. Attached as Exhibit R is a true and accurate copy of the Bylaws, Bates labeled BYLAWS000036.

6. Attached as Exhibit S is a true and accurate copy of the May 8, 2019 Order.

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FURTHER DECLARANT SAYETH NAUGHT

DATED this 7th day of October, 2021.

HALL PRANGLE & SCHOONVELD, LLC

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

No notary required per NRS 53.045

I.

ARGUMENT

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

Plaintiff's Response does not acknowledge that there was one - - and only one - - basis of this Court's order: at the time of the Motions to Apply the Trauma Cap, the Court found an issue of fact as to whether there was a "trauma." *See,* Exhibit B to NNHR's Motion for Partial Summary Judgment, p. 4, lns 12-14. Since that time, that issue of fact has been resolved: Plaintiff's experts concede that this was a trauma. Plaintiff tries to get around her experts' concessions by claiming that the "definition" of the injury was not met. However, the statute gives two options for meeting the definition: "either significant risk of death" **OR** "precipitation of complications or disabilities." All of the quotes she submits are on the former, but on the latter, Dr. Womack agrees: for example, Mr. Schwartz "had trace hyperdense fluid in his belly . . . and it is standard of care for somebody with this CT reading to have a surgical consult . . . because this could be a potential surgical injury." *See,* Exhibit C to NNRH's Motion for Partial Summary Judgment, pp. 163-164. Potential surgery is clearly a precipitation of complication from the hit-and-run falling squarely within the trauma definition of the statute.

Similarly, as to the language of the exception, Plaintiff chooses to focus only upon one part of NRS 41.503(2)(a) and ignores the required second part. She focuses upon "after the patient is stabilized" but ignores the necessary "**AND**" following it: "**and** is capable of receiving medical treatment as a nonemergency patient." *See,* NRS 41.503(2)(a) (emphasis added). Fatal to

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Plaintiff's argument, she provides no evidence whatsoever that Mr. Schwartz was so capable, instead only referring back to "stability." Because Plaintiff provided no evidence whatsoever on "capability of receiving medical treatment as a non-emergency patient", for summary judgment purposes, this Court must conclude that the second, necessary part of 41.503(2)(a) has not been met. Plaintiff attempts to distract the Court with discussion of vital sign stability, but even the legislative comments inextricably tie stability to "capable of receiving medical treatment as a non-emergent patient": in response to a question from Assemblyman Marvel, Dr. Michael Daubs stated that, from his standpoint, a patient was stabilized if he was discharged from the clinic; the condition had been treated and he did not have to return to the clinic. *See,* **Exhibit O**, Assembly Minutes. Plaintiff's fatal omission of any evidence that Mr. Schwartz was "capable of receiving medical treatment as a non-emergency patient" was caused by the fact that all of her experts conceded emergent transfer from NNRH to the University of Utah was appropriate.

As to the Plaintiff's attempt to apply the 41.503(2)(b) exception for injury "unrelated to the original traumatic injury," Plaintiff is ludicrously claiming that the emergency room care was unrelated to Mr. Schwartz being hit by a car traveling 30 miles per hour: Plaintiff is even trying to keep mention of the hit-and-run out of the courtroom (See Plaintiff's Motion in Limine No. 2 to exclude evidence of prior accidents or injuries). Clearly Mr. Schwartz would not have been in the emergency room receiving care but for the hit-and-run. Plaintiff's ridiculous argument should not be allowed to be considered given the legislative intent behind the statute: that the physicians accepting trauma patients were seeing their insurance premiums going up and were not willing to bring them into the hospital without this assistance. Plaintiff's response correctly quotes the committee comments on heart attacks; yes, this statute was not intended to cover all emergent medical conditions, only traumas, and the plain language of the statute discusses "injuries."

Finally, this Court did not address the concept of gross negligence in her order because it has already ruled - - twice, once by this judge and once by her predecessor - - that claim will not be allowed. To consider this argument, Plaintiff is asking this Court to overturn its two prior orders. Plaintiff is desperate to avoid the eventual reality of the trauma cap, including having this Court vacate her prior hard work on that motion practice.

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If there ever was a case to which the trauma cap applied, it is to a man brought into the hospital after being hit at 30 miles per hour with head, abdominal, and musculoskeletal imaging abnormalities requiring emergent transfer to a higher level of care. At the time the motion to apply the caps was brought, this Court found an issue of fact which since has been resolved by Plaintiff's experts. Now is the time to grant this motion such that the Writ already filed on the previous one can be vacated and the risk of a re-trial eliminated.

B. Summary Judgment is warranted as to the application of NRS 41A pursuant to *Estate of Mary Curtis, et al., v. Life Care Center of So. Las Vegas, et. al*, 466 P.3d 1263 (Nev. 2020).

To distract this Court from the lack of evidence to support any theory of liability asserted against NNRH in Plaintiff's Complaint, Plaintiff's Opposition is now re-characterizing the claims against NNRH and Dr. Garvey as "ordinary negligence" despite not being pled as such. This last-minute theory change is not surprising given counsel is desperate to avoid this Court's prior orders in this case, as well as the statutory restrictions that apply to professional negligence actions.

As support for Plaintiff's self-serving characterization of the claims as contemplating ordinary negligence, Plaintiff's Opposition cites the "common knowledge exception" set forth in *Estate of Mary Curtis, et al., v. Life Care Center of So. Las Vegas, et. a*), 466 P.3d 1263 (Nev. 2020). Although the Nevada Supreme Court has recognized a "common knowledge exception" that removes a case from the professional negligence statutory scheme, the Court specifically stated that the "exception's application is extremely narrow and only applies in rare situations." *Id.* at 1268. As set forth below, this is not one of those situations.

Regardless, Plaintiff's Opposition also ignores the Court's holding in *Estate of Curtis* that derivative claims – including negligent staffing, training, supervision, budgeting, etc. – are subject to NRS 41A when the claims are "inextricably linked" to the underlying medical treatment, which is clearly the case with any of Plaintiff's claims against NNRH.

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1. Plaintiff's claims against NNRH are subject to NRS 41A because the "common knowledge exception" is inapplicable to this case.

Plaintiff's reliance on the Common Knowledge exception to exempt this case from the purview of NRS 41A is misplaced because Plaintiff's claims against NNRH arise out of the professional hospital-patient relationship and involve questions of medical judgment.

To determine whether the common knowledge exception applies to a particular case, the Nevada Supreme Court has adopted the following test:

> (1) whether the claim pertains to an action that occurred within the course of a professional relationship; and (2) whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience. If both these questions are answered in the affirmative, the action is subject to the procedural and substantive requirements that govern professional negligence actions."

Estate of Curtis v. S. Las Vegas Med. Inv'rs, LLC, 136 Nev. Adv. Op. 39, 466 P.3d 1263, 1268 (2020). In adopting this framework, the Nevada Supreme Court reiterated that "the exception's application is extremely narrow and only applies in rare situations." *Id.* at 356, 466 P.3d at 1268. As a matter of fact, the Court cited to cases for the proposition that the exception is limited to "situations of blatant negligence" that do not "involve professional judgment," and only applies where "the causal link between the injury and the negligence is apparent to a person with no medical training." *See id.* (citing *Smith v. Gilmore Mem'l Hosp., Inc.*, 952 So. 2d 177, 180-182 (Miss. 2007) and citing *Bowman v. Kalm*, 179 P.3d 754, 756 (Utah 2008)). The examples offered by the Nevada Supreme Court included a nurse administering a patient a medication that was prescribed to a different patient, a dentist extracting the wrong tooth, and a pharmacist filling a prescription with the wrong drug. *Id.* at 355, 466 P.3d at 1268 (citing *Bender v. Walgreen E. Co.*, 399 N.J. Super. 584, 945 A.2d 120, 122-123 (N.J. Super. Ct. App. Divi. 2008), *Walter v. Wal-Mart Stores, Inc.*, 748 A.2d 961, 972 (Me. 2000), and *Hubbard ex rel. Hubbard v. Reed*, 168 N.J. 387, 774 A.2d 496, 500-01 (2001)).

Conveniently, Plaintiff's Opposition fails to mention the express framework adopted by the Nevada Supreme Court, despite advocating for application of the common knowledge exception. This is not surprising since the answer to both questions set forth by the Nevada Supreme Court is a resounding "yes".

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First, it is undisputed that the alleged negligence in this case occurred within the course of the professional relationship between Mr. Schwartz and NNRH as Mr. Schwartz's was undeniably a hospital patient at the time of his treatment.

Next, despite Plaintiff's self-serving statements to the contrary, whether Reach transport personnel should have been involved in the intubation of Mr. Schwartz clearly "raises questions of medical judgment beyond the realm of common knowledge and experience." Certainly, a lay person having no experience treating patients in a hospital has insufficient experience to say whether it is appropriate for an emergency department physician to enlist the services of a transporting EMS crew to perform an intubation while the doctor places a chest tube prior to air transport to a trauma center. *Cf. Symborski v. Spring Mountain Treatment Ctr.*, 133 Nev. 638, 647, 403 P.3d 1280, 1288 (2018) (holding "if the jury can only evaluate the plaintiffs claim after presentation of the standards of care by a medical expert, then it is a [professional negligence] claim")).

As a matter of fact, Plaintiff ironically seeks to prove her claims against NNRH through Dr. Burroughs, an expert claiming experience as both an emergency department physician and hospital administrator. Dr. Burroughs concedes that air transport personnel may assist a physician with treatment in an emergency department but disagrees that they may perform an intubation in an emergency department under the direction of a physician. *See* **Exhibit P** at 194:8-20. As the defense experts hold the contrary opinion, it is quite evident this is not the "blatant negligence" that warrants the application of the common knowledge exception detailed in *Estate of Curtis*. Certainly, ascertaining the scope of assistance an EMS transport crew may provide in hospital is not a situation akin to a nurse administering medication to the wrong patient, a dentist extracting the wrong tooth, or a pharmacy misfilling a prescription. *Cf. Estate of Curtis*, at 355, 466 P.3d at 1268.

Finally, the references in Plaintiff's Opposition to the hospital bylaws and contract between Dr. Garvey and his group are irrelevant to whether the claims sound in professional negligence. This is not a breach of contract action and there is no cause of action for a hospital's violation of bylaws. The issue is whether the hospital and Dr. Garvey breached the "standard of

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care" regarding either the decision to intubate, or the manner in which the intubation was conducted. While Plaintiff's counsel may misrepresent the bylaws and contract to suggest that a breach occurred, the documents in and of themselves do not create any claim of relief to Plaintiff even if there are deviations therefrom. As testified to by Barry Bartlett, intubations are routinely performed in emergency departments across the country the air transport companies. *See* Deposition of Barry Bartlett Pg. 35 Ln. 5-7 attached as **Exhibit Q**. Regardless, the bylaws themselves authorize "any member the medical staff, . . . regardless of department, staff status, or clinical privileges, . . . to do everything reasonably possible to save the life of a patient or save a patient from serious harm" in an emergent situation. See **Exhibit R** Bates labeled BYLAWS000036. Here, the "member of the medical staff" making that decision was Dr. Garvey, the person in the room with the most education, training, and knowledge as to how the save the patient from serious harm. The common knowledge exception is inapplicable.

2. Plaintiff's claims against NNRH are subject to NRS 41A because they are inextricably linked to the allegedly negligent intubation that caused Mr. Schwartz's death.

In addition to misapplying the "common knowledge exception," Plaintiff's Opposition completely ignores the *Estate of Curtis* holding that direct claims against a facility are subject to NRS 41A if those claims are "inextricably tied" to underlying professional negligence. Plaintiff instead prefers to cite to cases from other jurisdictions to suggest that claims for staffing, supervision, credentialing, etc. are ordinary negligence claims.

However, this Court need not look to other jurisdictions for guidance as the Nevada Supreme Court has addressed the issues. In *Estate of Curtis* the Court specifically denounced the tactic Plaintiff is taking in this case, which is an attempt to circumvent NRS 41A by asserting negligent hiring, training, staffing, and supervision claims directly against a facility. The Court stated:

> we therefore clarify that negligent hiring, training, and supervision claims cannot be used to circumvent NRS Chapter 41A's requirements governing professional negligence lawsuits when the allegations supporting the claims sound in professional negligence.

The Court further explained that where direct claims against a facility are "inextricably linked" to underlying professional negligence, the claims are subject to NRS 41A regardless of

their title. *See Estate of Curtis v. S. Las Vegas Med. Inv'rs, LLC*, 136 Nev. Adv. Op. 39, 466 P.3d 1263, 1267 (2020).

In *Estate of Curtis*, a nurse was alleged to have provided plaintiff-decedent, Curtis, with another patient's medication and thereafter is alleged to have failed to monitor or treat Curtis leading to her death. *Id.* The plaintiff alleged that the nurse's employer (LCC) was negligent by "mismanagement," "understaffing," and "operation of the nursing home" leading to Curtis' death. *Id.* The express claims included in the Complaint against the facility did not include any express claim for professional negligence. The plaintiff thus sought to avoid the restrictions imposed by NRS 41A.

The Court refused Plaintiff's attempts to avoid the NRS 41A restrictions. This was notwithstanding the fact that there was no stated claim for professional negligence in the Complaint, and the fact that, unlike NNRH here, the nursing facility was *not* a provider of health care under NRS 41A.015. The Court justified the ruling stating: "if the underlying negligence did not cause Curtis's death, no other factual basis was alleged for finding LCC liable for negligent staffing, training, and budgeting." *Id.* at 1268.

The Nevada Supreme Court in *Zhang, M.D. v. Barnes*, 832 P.3d 878, Nev. Unpub. Disp., WL 4926325, Docket No. 67219, Filed September 12, 2016 (holding affirmed in the *Estate of Mary Curtis, et al., v. Life Care Center of So. Las Vegas, et. al*), 466 P.3d 1263 (Nev. 2020), similarly reasoned that NRS 41A applies to derivative claims because "[t]here would have been no injury . . . and no basis for the [plaintiffs'] lawsuit without the negligent rendering of professional medical treatment."

Here, like *Zhang* and *Curtis*, Plaintiff's proposed claims for relief against NNRH are all derivative and continent upon the negligent medical treatment that is the sole alleged cause of Mr. Schwartz's death. In fact, Plaintiff *has* expressly included a professional negligence cause of action in the Complaint, and NNRH *is* a provider of health care under NRS 41A.015. Hence, the applicability of NRS 41A is even more clear in this case than it was in *Curtis*, where there was no claim for professional negligence and the nursing facility was not a provider of health care as defined by NRS 41A.015.

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It is thus understandable that Plaintiff's Opposition ignores these holdings in *Zhang* and *Estate of Curtis,* particularly since Plaintiff is attempting the very tactics that have been repeatedly rejected by the Nevada Supreme Court. Again, Plaintiff's proposed claims against NNRH, be it failing to credential Reach, appropriately staff the emergency department, or institute adequate policies and procedures, are contingent on the allegedly negligent intubation having caused Mr. Schwartz's death. In other words, all of Plaintiff's claims – regardless of the title given them by Plaintiff – are completely interdependent and inextricably tied to the allegedly negligent medical treatment. As such, the claims are subject to the requirements and provisions of NRS 41A regardless of Plaintiff's self-serving characterization of the claims.

C. Summary Judgment is warranted as to Plaintiff's First Claim for Relief – Professional Negligence – because Plaintiff's proposed claims regarding inadequate policies and vicarious liability for Reach Air are impermissible.

Plaintiff's Opposition does not dispute that Plaintiff's Complaint contains absolutely no allegations that NNRH itself was negligent. This is another reason Plaintiff is concocting ordinary negligence claims out of thin air under the guise of notice pleading. Apparently, Plaintiff's counsel interprets notice pleading to mean that no allegations, facts, or claims even need to be plead. Rather, NNRH should have anticipated these direct claims even though: (1) there are no direct claims or allegations of negligence in the Complaint, and (2) Plaintiff never sought leave to bring any such claims against NNRH in the four years that this case has been pending. However, Rule 8 does not excuse a party from seeking leave of Court to amend a complaint to assert new claims for relief.

This is particularly true where, as here, the claims at issue are for professional negligence. This is because professional negligence actions modify the notice pleading requirements by requiring an expert affidavit support any claim for relief asserted against a provider of healthcare. Indeed, pursuant to NRS 41A.071 a claim for professional negligence against a provider of health care, such as NNRH, must be supported by an affidavit of merit that separately identifies the negligence of each defendant. *See* NRS 41A.071. If an affidavit does not support negligence against a particular defendant, the claims are "void and must be dismissed; no amendment is permitted." *See, e.g., Washoe Med. Ctr. v. Second Judicial Dist.*

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Court, 122 Nev. 1298, 1304, 148 P.3d 794 (2006) (holding that a complaint filed without a qualifying expert affidavit is "is void and must be dismissed; no amendment is permitted"); *see also Fierle v. Perez*, 125 Nev. 728, 738, 219 P.3d 906, 912 (2009) (stating that NRS 41A.071 "applies even when only some of the claims violate the NRS 41A.071 affidavit requirement").

In fact, at the inception of this case a motion to dismiss was filed pursuant to NRS 41A.071. In ruling on that Motion to Dismiss, this Court expressly ruled that (1) NNRH did not have a non-delegable duty of care for the actions of the hospital's independent contractors; and (2) NNRH may be liable to Plaintiff under a theory of ostensible agency, with Plaintiff permitted to "maintain suit against [NNRH] for professional negligence/wrongful death because the discovery process has not progressed to the point where the nature of the agency between Dr. Garvey and [NNRH] can be determined." *See* May 8, 2019 Order Pg. 2 Ln. 26 – Pg. 3 Ln. 10 attached hereto as **Exhibit S**. Moreover, in the briefing on the Motion to Dismiss Plaintiff conceded the claims asserted against NNRH were derivative of Dr. Garvey's alleged negligence, arguing that Plaintiff had "properly pleaded that *Defendant Dr. Garvey's actions fell below the standard of care, and those actions are imputed to Defendant NNRH.*" *See* Opposition to Motion to Dismiss (emphasis added).

In other words, this is the law of the case. The law-of-the-case doctrine embodies the general concept that a court involved in later phases of a lawsuit should not re-open questions decided (i.e., established as law of the case). *Estate of Adams By and Through Adams v Fallini*, 132 Nev 814, 819 (2016).

Here, the "proposed" claims Plaintiff cites in Opposition to the Motion for Summary Judgment are in direct conflict with this Court's prior order. This is because this Court specifically ruled that NNRH did not have a non-delegable duty of care for the actions of the hospital's independent contractors (i.e. Reach employees), and this Court limited Plaintiff's Professional Negligence claim against NNRH ostensible agency for Dr. Garvey. *See* **Exhibit S**, Pg. 2 Ln. 26 – Pg. 3 Ln. 10. Plaintiff's belated, improper attempt to ignore or otherwise invalidate these prior rulings to assert new, direct claims for relief via an Opposition to a Motion for Summary Judgment one month before trial, should be denied.

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D. Summary Judgment is warranted as to Ostensible Agency because there is no evidence that Mr. Schwartz believed Dr. Garvey was employed by NNRH.

In Order to recover on a theory of ostensible agency, Plaintiff is required to plead and prove: (1) whether a patient entrusted himself to the hospital; (2) whether the hospital selected the doctor to serve the patient; (3) whether a patient reasonably believed the doctor was an employee or agent of the hospital; and (4) whether the patient was put on notice that a doctor was an independent contractor. *Schlotfeldt v. Charter Hospital of Las Vegas*, 112 Nev. 42, 49 (Nev. 1996). *Schlotfeldt* holds that it is the reasonableness of the patient's belief that the doctor is employed by the hospital which forms the third element of the analysis. *Id.*

Here, Plaintiff has offered no evidence that Mr. Schwartz believed that Dr. Garvey was an employee of NNRH. Plaintiff cites directly to Mrs. Schwartz's deposition, but that deposition does not contain any admissible evidence which supports the contention that Mr. Schwartz believed that Dr. Garvey was employed by NNRH. Plaintiff also fails to support the "reasonable belief" element with any evidence or argument in her Opposition. Plaintiff misstates this standard by arguing about the reasonableness of Mrs. Schwartz's belief regarding Dr. Garvey's employment status. However, that is not the standard. *Id.* Plaintiff is unable to present any admissible evidence about the reasonableness of Mr. Schwartz's belief in Dr. Garvey's employment status, therefore the agency allegations should be dismissed.

E. Summary Judgment is warranted as to "Negligent Credentialing" since Plaintiff has offered no argument, legal authority, or evidence to support the claim.

Plaintiff's Opposition has offered no authority to suggest that Nevada does, or would, recognize a cause of action for Negligent Credentialing. As it is, the Nevada Supreme Court has never recognized the cause of action so this Court would be the first. *See, e.g. Nogle v. Beech St. Corp.*, No. 2:10-CV-01092-KJD, 213 WL 1182680, at *3 (D. Nev. Mar. 20, 2013) (stating that "no [Nevada] authority has specifically recognized a cause of action for negligent credentialing"), *aff'd*, 619 F. Appx. 639 (9th Cir. 2015).

Moreover, since the elements of such a cause of action have not been established, Plaintiff's attempt to plead such a cause of action necessarily fails. Regardless, as stated in the Motion the issue is moot since Plaintiff's position is that "Dr. Garvey is well-trained and

qualified emergency physician." *See* Exhibit N to NNRH's Motion for Partial Summary Judgment, Bates labeled Schwartz 000487. Not only are Plaintiff's experts not critical of the credentialing of Dr. Garvey, Plaintiff failed to address this issue in opposition. Therefore, the allegations that Dr. Garvey was inappropriately should be dismissed.

F. Summary Judgment is warranted as to Negligent, Hiring, Training, and Supervision as to NNRH – since there is no evidence to support such a claim.

Plaintiff has likewise conceded the issue of Negligent, Hiring, Training, and Supervision of NNRH employees. Plaintiff's Third Claim for Relief includes vague allegations that NNRH improperly hired, trained, and supervised its employees and independent contractors. There is no evidence that any employee of NNRH was negligently hired, trained, or supervised. There is also no expert support for any professional negligence of a hospital employee, rendering a negligent hiring, training, supervision claim an impossibility given there is no causal connection between any hypothetical failure in the hiring/supervision process. Plaintiff also failed to respond to this issue in opposition, summary judgment on these claims is thus warranted.

II.

CONCLUSION

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

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AFFIRMATION

Pursuant to NRS239B030

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

DATED this 7th day of October, 2021.

HALL PRANGLE & SCHOONVELD, LLC

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Index of Exhibits:

Minutes of the Assembly Committee on Medical Malpractice Issues, July 31, 2002, attached hereto as **Exhibit O**

Deposition of Jonathan Burroughs, attached hereto as **Exhibit P**

Deposition of Barry Bartlett, attached hereto as **Exhibit Q**

Bylaws, Bates labeled BYLAWS000036, attached hereto as **Exhibit R**

May 8, 2019 Order, attached hereto as **Exhibit S**

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC; that on the 7th day of October, 2021, I served a true and correct copy of the foregoing **DEFENDANT PHC-ELKO, INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL'S REPLY IN SUPPORT OF MOTION FOR PARTIAL SUMMARY JUDGMENT** via electronic service and US Mail to the following:

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Exhibit O

Exhibit O

MINUTES OF THE MEETING OF THE ASSEMBLY COMMITTEE ON MEDICAL MALPRACTICE ISSUES

Eighteenth Special Session
July 31, 2002

The Committee on Medical Malpractice Issues was called to order at 1:20 p.m., on Wednesday, July 31, 2002. Chairman Bernie Anderson presided in Room 4100 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer Office Building in Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Guest List. All exhibits are available and on file at the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Mr. Bernie Anderson, Chairman
Ms. Barbara Buckley, Vice Chairman
Mr. Bob Beers
Mr. David Brown
Mrs. Barbara Cegavske
Mr. Joseph Dini, Jr.
Mr. Lynn Hettrick
Mrs. Ellen Koivisto
Ms. Sheila Leslie
Mr. Mark Manendo
Mr. John Marvel
Mr. John Oceguera
Ms. Genie Ohrenschall
Ms. Bonnie Parnell
Mr. Richard D. Perkins

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblyman Doug Bache, District 11
Assemblyman John Carpenter, District 33
Assemblywoman Vivian Freeman, District 24
Assemblyman David Humke, District 26
Assemblywoman Kathy McClain, District 15
Assemblywoman Kathy Martin, District 20
Assemblyman Bob Price, District 17
Assemblywoman Sandra Tiffany, District 21

STAFF MEMBERS PRESENT:

Nicolas Anthony, Senior Research Analyst
Risa Lang, Principal Deputy Legislative Counsel
Allison Combs, Principal Research Analyst
Cindy Clampiitt, Committee Secretary
June Rigsby, Committee Secretary

Linda Smith, Committee Secretary

OTHERS PRESENT:

Dr. Denise Selleck Davis, Executive Director, Nevada Osteopathic Medical Association
Jason Geddes
Robert Roshall, LVMPD
Gus Flangas, Physician's Task Force
Dr. John Haller, General and Vascular Associates
Dr. Michael Daubs, Nevada Orthopedic Society, Concerned Physicians of Nevada
Dr. Robert McBeath, Nevada Medical Liability Physicians Task Force, COPN
Dr. Dan McBride, Physicians Task Force and President of the American College of Surgeons
Stan Olsen, LVMPD
Dr. James Tate, General Surgeon, President of the West-Crear Medical Society
Jim Wadhams, American Insurance Association (AIA), Nevada Hospital Association (NHA), Nevada Independent Insurance Association (NIIA)
Brian Hock
Bill Welch, Nevada Hospital Association (NHA)
Gerald Gillock, Nevada Trial Lawyers Association (NTLA)
Dr. Don Havins, Clark County Medical Society
Dr. Michael Fischer, Ophthalmologist
Robert Barengo, representative for Sunrise Hospital

The roll was called, and Chairman Anderson declared a quorum was present. It was announced that Assemblywoman Koivisto and Assemblywoman Leslie were testifying in the Senate and were excused. Speaker Perkins and Assemblywoman Buckley were working on Assembly matters and were excused. Assemblyman Dini was expected to arrive shortly. Chairman Anderson addressed the audience and asked if representatives of the medical community were present.

Chairman Bernie Anderson announced the first order of business would be a review of S.B. 2. He requested Risa Lang, Principal Deputy Legislative Counsel, to present a comparison between A.B. 1 and S.B. 2.

Risa Lang, Principal Deputy Legislative, called the committee's attention to the document "Comparison of Assembly Bill No. 1 (First Reprint) and Senate Bill No. 2 (Proposed First Reprint with Amendment No. 2)" (Exhibit C) and commenced testimony. She reminded the committee that they had already reviewed A.B. 1, and she would focus on the differences with S.B. 2.

Senate Bill 2: Makes various changes related to medical and dental malpractice. (BDR 3-13)

Section 1 of A.B. 1 corresponded to Section 1 of S.B. 2. That section provided for the $50,000 cap for hospitals and employees of either a governmental hospital or a nonprofit hospital. Subsection 2 provided for the limitation to apply to for-profit organizations that rendered care to a patient in an acute life-threatening situation. Subsection 1 contained clarification of language designed to resemble the language contained in the sovereign immunity statute. The purpose was to ensure that case law applied to the sovereign immunity statute would be carried forward for interpretation purposes.

Assemblyman Dini interjected with a request to review the bill language by citing specific lines.

Ms. Lang resumed testimony and clarified she was referring to a copy of S.B. 2 itself, and she was not reading from the amendment document (Exhibit C). The amended language was contained on page 2, lines 36 and 37, and read "exclusive of interest computed from the date of judgment, to or for the benefit of any claimant arising out of any act or omission." That language was taken from the *Nevada Revised Statutes* (NRS) 41.035, the sovereign immunity statute.

Chairman Anderson requested clarification of the extension of sovereign immunity to for-profit institutions. Ms. Lang stated it was not an extension of sovereign immunity, rather it was merely language borrowed from the sovereign immunity statute. Case law would be applied in a similar manner in reading those words under subsection 1.

Subsection 2 was described as new language in the Senate bill that was not included in the Assembly bill. It extended the same limited liability of $50,000 to for-profit hospitals or those hospitals that were not covered by subsection 1 in situations where they provided assistance in an acute life-threatening medical condition.

Chairman Anderson asked for the specific location of the language "acute life-threatening situation." Ms. Lang clarified it was on page 3, line 2, of S.B. 2.

Assemblywoman Parnell summarized by stating the language greatly expanded the population of people who would be covered by the $50,000. Ms. Lang concurred with her statement and explained it would include hospitals that would not have been previously covered. In reference to that population added in the Senate bill, Assemblywoman Parnell asked how those doctors were currently covered. Ms. Lang explained they would be operating under the cap of $350,000 noneconomic damages and under no cap for economic damages. Assemblywoman Parnell restated her question with an emphasis on the word "currently." Ms. Lang clarified that currently there were no caps. Section 1 included designated trauma centers, and, in Nevada, there were three centers, UMC, Washoe, and Churchill. The proposed language would extend coverage, and she illustrated her point with the example of an acute life-threatening event in Carson City.

Assemblywoman Cegavske requested clarification of the language in both bills and asked if an anesthesiologist fit under the guidelines and definition of a physician. Ms. Lang replied in the affirmative and added that the anesthesiologist would have to be licensed under NRS 630 or NRS 633. If the anesthesiologist rendered care in one of the identified institutions under a trauma situation, he would be covered.

Chairman Anderson asked if the words "demanding immediate medical attention" was a bill drafter's usage or if the language needed to be modified to add language such as "caused by." Ms. Lang explained the language was modeled after a statute in another state. She was unsure if it required further modification. She clarified the language was also contained in A.B. 1.

Assemblyman Dini summarized by saying it covered "any emergency room in the state." Ms. Lang agreed; however, in subsection 2 there was language that required it be an "acute life-threatening situation." Referring to subsection 1, lines 33 and 34 of S.B. 2, Ms. Lang cited the language "serious medical condition" and explained that was the standard to be applied for nonprofits and governmental hospitals. For others, including for-profit hospitals, in subsection 2 on page 3, line 2, it required it be an "acute life-threatening medical condition." Ms. Lang stated it was a slightly more serious standard to be met compared to subsection 1. It would not apply in as many situations.

Assemblyman Dini voiced confusion regarding the differences between "serious medical condition" and "acute life-threatening condition." He asked if it amounted to a different standard. Ms. Lang acknowledged there was a difference in standards depending on whether it involved a nonprofit, governmental organization, or a for-profit hospital under subsection 2. In order to be covered under the new limited liability, the doctors in a for-profit hospital would have to be providing care in an "acute life-threatening condition." If you provided care in a nonprofit or governmental institution, it would apply to situations that were deemed to be a "serious medical condition."

Assemblyman Dini reiterated his confusion and illustrated his question with a hypothetical situation of an emergency room in Lovelock. If the patient was very sick but judged to not be in an "acute life-threatening situation," and he arrived at the emergency room, he would not be covered. He asked how the determination of coverage would be made in a consistent manner.

Ms. Lang admitted she did not know the reason for choosing that standard in the proposed legislation. Initially it had only applied to nonprofit and governmental entities and their physicians. When the Senate made the decision to extend coverage to other hospitals in Nevada, they chose to limit the medical situations in which it would be applicable. If the doctor was not covered by the $50,000 limit, it would go to the other limits that were provided in the bill.

Assemblyman Dini added that he did not necessarily disagree with the concept, but it appeared to be confusing. Chairman Anderson interjected it would be advisable to bring in a witness who advocated for that position on the Senate side.

Assemblywoman Parnell stated the universal coverage was acceptable, but she voiced some discomfort over situations where a determination had to be made about the status of the patient and whether the coverage applied in that case.
Chairman Anderson summarized the committee's need for a witness to clarify Section 1 and subsections 2 and 3 of the bill, especially the language governing emergency room situations. Assemblywoman Parnell concurred and requested the witness be able to clarify who would render the decision regarding the patient's status.

Assemblyman Beers offered to address the philosophy of the issue. Chairman Anderson stated it was essential to allow Ms. Lang to continue her review of the bill without interruption.

Risa Lang resumed testimony and offered to clarify Assemblywoman Parnell's concerns. The decision of the patient's status would most likely be decided in court. It would be a factual determination for the jury.

Returning to the bill, Ms. Lang explained the Senate had added a new subsection 4 which provided a "rebuttable presumption" provision concerning follow-up medical care. In response to Chairman Anderson's confusion about the line number, Ms. Lang clarified she was in subsection 4, page 3, line 20 of S.B. 2 (First Reprint). The $50,000 cap would continue to apply under the presumption the patient's condition related to his initial medical event. Chairman Anderson requested clarification on time limits. He illustrated his question with the example of a physician who provided follow-up care for a heart attack victim. The patient had been initially treated in an emergency room and, at that time, the $50,000 cap was in effect because it was a life-threatening situation. In the aftercare situation, at what point did that patient's status change?

Ms. Lang called the Chairman's attention to paragraph b of subsection 4 on line 24. The follow-up care had to be related to the original medical condition that brought the patient to the emergency room. Chairman Anderson continued with his example and asked at what point the $50,000 cap expired. Ms. Lang clarified it was just a "rebuttable presumption." It did not say follow-up care would definitely be an extension of the original care. As such, the presumption could be overcome as time passed; however, the language stated it was related to the original medical condition, was provided during the course of follow-up care, and the malpractice action was the result of something that happened during the follow-up care. If determined to be a closely related medical situation, then it would be judged to be a rebuttable presumption. It followed from the original care, and coverage was in place under that cap.

Assemblyman Marvel asked at what point the $50,000 cap would expire; Ms. Lang explained that, under the current language of the Senate bill and the Assembly bill, the cap would "go away" when the patient became stable. That language was contained in subsection 3 on page 3. If the physician began to provide additional care that was unrelated to the original emergency event, the cap would no longer apply.

In response to Assemblyman Marvel's question about who made the determination after the patient was stabilized, Ms. Lang explained it would be a factual issue to be determined during the course of litigation. The definition in the bill was "stabilized and is capable of receiving medical treatment as a nonemergency patient." Assemblyman Marvel asked if the initial treating physician made that determination. Ms. Lang was unsure of specific hospital procedures; however, it was directly tied to the point when the patient was no longer considered an emergency. An exception would be surgery that was required as a result of the emergency. That language was the same in both bills. The difference between the two bills was the Senate's version had added language on the

subject of "for-profit." Additionally, subsection 4 contained the provision of "rebuttable presumption" for follow-up care. Ms. Lang continued her summary of differences by referencing subsections 2 and 4 and the cleanup language that tied the bill more closely to NRS 41.035.

Assemblyman Brown called attention to subsection 4C, the "rebuttable presumption" provision that he interpreted as tying the second medical condition to the first event. At lines 28 and 29, the language appeared unusual to Assemblyman Brown. There was a rebuttable presumption that the second medical condition was caused by the care or assistance rendered pursuant to subsection 1 or 2. It seemed to suggest the causation for the medical condition was the physician's efforts, but not that it was a spillover from the initial medical condition. The presumption appeared to be the second condition arose from the first and not from the physician's care.

Chairman Anderson reminded the committee there would be witnesses who would clarify and debate those points. Ms. Lang's duty was to review the language of the bill.

Ms. Lang resumed testimony and agreed the language might need to be tightened on those issues. She summarized by stating that she had covered the "differences between S.B. 2 and S.B. 1 for that Section." Chairman Anderson asked if there were any additional questions regarding Section 1 of S.B. 2.

Ms. Lang called the committee's attention to Section 2 and the next major difference between the Senate and Assembly bills. The Senate bill added a new subsection 5 on page 3 of S.B. 2. That section amended NRS 41.505 that contained "Good Samaritan" provisions. The next addition to S.B. 2 was subsection 5 on page 5 of the bill that would give total immunity to medical doctors, osteopathic physicians, and dentists who, in good faith, provided medical care to a patient free of charge at a nonprofit or governmental health care facility.

Assemblyman Marvel asked if that language was the "Good Samaritan" statute. Ms. Lang confirmed it was contained in the Good Samaritan statute.

Ms. Lang called the committee's attention to Section 2 of S.B. 2, when Chairman Anderson announced that the Ways and Means Committee would be meeting at 2:30 p.m., and that required a recess of his committee at 2:15 p.m. Chairman Anderson called new witnesses to the table and summarized the current discussion centered on S.B. 2. He explained there were committee concerns regarding the language on page 2 and the expansion of emergency room coverage to additional hospitals. Chairman Anderson asked the witnesses to clarify the intent of the language.

Gus Flangas, an attorney representing the Physicians Task Force, introduced his colleagues, Dr. Robert McBeath (to his left) and Dr. Michael Daubs (to his right).

Assemblywoman Parnell voiced concern about the addition of a new population of doctors and the clear standard to be met for the $50,000 liability coverage. If a clear standard was established, her second concern was that the determination would not be made until the matter reached a court of law. She asked for clarification on that process.

Before addressing Assemblywoman Parnell's concerns, Mr. Flangas offered to review the background information that led to insertion of the language. The University Medical Center (UMC) Trauma Center in Las Vegas was extremely vital to Clark County and areas of Arizona and California. The UMC Trauma Center closed its doors in July for 10 days. The impact was devastating to the community and was foretelling of events to come in northern Nevada. Mr. Flangas explained that UMC was a state facility, and it fell under the $50,000 limitation. The employees of UMC also fell under that limitation. The reason for the bill was to help the independent doctors who worked at UMC, but, in fact, were not employees of the UMC Trauma Center. Those doctors were paid $40 per hour to work on a voluntary basis. When they listed the UMC Trauma Center on their malpractice insurance applications, their premiums increased significantly. In Mr. Flangas' judgment, those doctors needed protection.

Mr. Flangas illustrated his point with an example of an independent doctor treating a patient at the UMC Trauma Center. That patient became his patient (i.e., professionally bound to continue with the care and treatment of that patient). The language that was inserted was somewhat designed to add more protection because of that obligation to perform follow-up work on that patient, regardless of location or time. Mr. Flangas explained the previous draft of the bill had no provision for follow-up work, and that caused great concern. It exposed the physician to the loss of the $50,000 coverage as originally drafted. The new language remedied that situation with the "rebuttable presumption" language. If there was an injury to the patient, it would be presumed to have occurred during the course of treatment for that trauma.

Chairman Anderson interrupted and reminded the witnesses that time was running out for questions from the committee. Mr. Flangas acknowledged the concern and summarized the issue of "rebuttable presumption."

Assemblywoman Parnell interrupted to clarify for the witness that her concern was not that section of the bill. She stated emphatically that there was not one person who would argue the need to protect the trauma doctors in Nevada. Assemblywoman Parnell voiced her concern over language in S.B. 2 that added a new population of doctors who, with special circumstances, would have that same $50,000 liability protection. She voiced additional concern over a clear definition of when the coverage would be applicable and who would make that determination.

Dr. Michael Daubs, an orthopedic surgeon, offered to respond. There existed clear definitions in the *Nevada Administrative Code* that defined a "trauma patient." If a patient qualified under that definition and was treated at a facility that was not a designated trauma center, the doctor would be protected by the proposed legislation.

Assemblywoman Cegavske reiterated an earlier question regarding the terminology "a physician" and asked if that included anesthesiologists in the treatment of trauma patients. Mr. Flangas replied in the affirmative.

Assemblyman Dini asked if coverage included nurse anesthesiologists. Mr. Flangas replied a nurse anesthetist would not be covered under that language. Chairman Anderson requested clarification from the Committee Legal Counsel. Ms. Lang called the committee's attention to subsection 1, page 2, line 17, where it read "an employee of a hospital who renders care." Ms. Lang explained it referred back to the nonprofit hospitals and centers. In regard to a for-profit facility, the same language was provided in subsection 2.

Following Chairman Anderson's clarification, Ms. Lang continued with her testimony and stated it applied to employees of a hospital. It was provided under both subsection 1 and subsection 2. In governmental hospitals, employees were already covered under the sovereign immunity statute. As such, they were not included in that part of the bill, but they did have coverage nonetheless.

Assemblyman Brown, addressing Assemblyman Dini's concern of nurse anesthetists, stated he believed that group had to carry their own professional insurance and were not necessarily classified as employees of hospitals.

In way of clarification, Dr. Michael Daubs stated it was his understanding nurse anesthetists were employed by hospitals.

Assemblyman Dini reiterated his comparison between lines 32-39 on page 2 (i.e., "serious medical condition requiring immediate medical attention") versus the language on line 2 of page 3 where it stated "acute life-threatening medical conditions." He observed there was a difference in standards between the two cited areas of S.B. 2.

Gus Flangas offered to respond and stated there was no clear answer to that concern. He suspected it happened in the drafting of the bill, and he was unsure if there was any actual distinction in the language. Chairman Anderson predicted that upcoming testimony from the hospital administrators and their attorney would resolve that issue.

Assemblyman Marvel asked when the $50,000 protective cap expired for a patient judged to be stabilized and who made that determination. Dr. Daubs offered to respond, and he acknowledged the issue of stabilization was a difficult one in the medical community. The language was added because the doctor's initial contact with a patient was usually the first of several appointments. From his standpoint, a patient was stabilized if he was discharged from the clinic; the condition had been treated and he did not have to return to the clinic.

Assemblyman Marvel summarized by saying the $50,000 cap might be in place for a period of time. Dr. Daubs replied in the affirmative and, for many injuries, stated it could be 6-12 weeks.

Dr. Robert McBeath clarified that attempting to place a definite time limit on the $50,000 was not recommended. The intent was tied to the actual relationship between the doctor and patient as well as the nature of the injury. That relationship commenced when the doctor first treated the patient at the trauma center. The doctor's judgment that the patient could be discharged from his care was the essential point.

Assemblyman Marvel asked if, as a matter of formality, the physician waived his liability at the point the patient was stabilized. Was the doctor required to sign-off; Mr. Flangas replied that would not be feasible under the law to have the doctor waive his rights for personal injury, especially in a trauma situation. As far as the issue of time limit expiration, Mr. Flangas stated that if a charge of malpractice was raised during treatment, it would be essential to prove that the malpractice actually occurred during that treatment. That was the essence of the bill. If it could be demonstrated that the malpractice occurred in the follow-up treatment, the presumption no longer was in place. It would become a malpractice action based on events during follow-up actions.

Chairman Anderson illustrated the issue with an example of a patient who showed signs of cardiac arrest and went to the emergency room of a rural hospital. After the patient was stabilized, he was sent home with the expectation that his treatment would continue with his personal physician. Chairman Anderson asked if there was a point in time when the $50,000 coverage no longer applied in that case. He added that previous testimony indicated the question would become an arguable point in court proceedings.

Mr. Flangas replied that theoretically the $50,000 cap would continue as a presumption. In the hypothetical case posed by Chairman Anderson, Mr. Flangas took the example a step further. Several months passed uneventfully and then the patient had symptoms that caused him to see his doctor. The patient was erroneously told he had indigestion and not a heart attack. That case would be considered malpractice due to subsequent events outside of the trauma center, and the $50,000 cap no longer applied.

Chairman Anderson modified his hypothetical case and stated the patient showed up at the emergency room convinced he was having a heart attack. The attending physician diagnosed the condition as indigestion and sent the patient home. The patient died of a massive coronary attack in the hospital parking lot. Chairman Anderson asked if the $50,000 cap covered the physician and could be recovered by the patient's family.

Mr. Flangas requested clarification if the hypothetical patient had presented to the emergency room at the UMC Trauma Center. Chairman Anderson replied the patient was in Carson City. Dr. Daubs stated a heart attack was not considered a trauma and therefore would not be covered.

Dr. McBeath acknowledged there was some confusion in the language. The testimony in the Senate had centered on the example of the trauma victim being seen at another facility, not necessarily at UMC. During the Senate hearing, Dr. McBride illustrated the point with a case of a gunshot wound being handled at a community hospital.

Chairman Anderson voiced confusion and was still attempting to fully understand his hypothetical case. Because Nevada only had three designated trauma centers (i.e., Las Vegas, Reno, and Fallon), the likelihood of being seen in an emergency room of a hospital was very high for many Nevada citizens.

Dr. Daubs requested clarification if the hypothetical scenario was the example of a patient who was judged to be a trauma patient, but was not seen at a designated trauma center. Chairman Anderson read from lines 35-37 on

page 2 of the bill "enters a 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." Dr. Daubs responded the heart attack would not fall under the trauma criteria.

Risa Lang, Committee Legal Counsel, asked if the witness was referring to the way they defined the situation, for example, going into a designated trauma center. She voiced confusion over why a heart attack would not be judged as a serious medical situation for a person in an emergency room or a trauma center. She called attention to subsection 2 that did not refer to designated trauma centers, but specifically addressed hospitals. In the example given, it would be an acute life-threatening medical condition, and she was unsure why a heart attack did not fall into that category.

Dr. Dan McBride, a member of the Physicians Task Force and President of the American College of Surgeons, approached the witness table and offered to clarify the issue. In testimony before the Senate, the discussion centered on limiting the coverage to patients with traumatic injuries. It was never the intent to extend blanket coverage to all emergency room patients, such as heart attacks. It was designed to extend the same liability coverage of physicians in the trauma center to physicians treating trauma cases in other facilities and hospitals.

Chairman Anderson emphasized the need for language that was sufficiently narrow for interpretation purposes.

Gus Flangas asked Dr. Daubs to address the issue. Dr. Daubs echoed the testimony of Dr. McBride and stated it was never the intent to include all medical cases, such as heart attacks. Dr. McBeath declared the core of the issue was in the definition of a trauma patient, and there were statutory definitions in place. He advised the statutory definitions would provide guidance for the bill language.

Chairman Anderson thanked the witnesses for their testimony and called representatives of the hospital association to the witness table. Robert Barengo, representing Sunrise Hospital, commenced testimony and explained the bill had been sponsored by the physicians. The heart of the issue was the treatment of trauma cases in all medical facilities. All hospitals received trauma patients. Physicians had a major concern that by treating a trauma patient in an emergency room, their liability might differ from what they would have had at a designated trauma center. Mr. Barengo described the bill as an attempt to have the designation of "trauma" follow the patient to whatever facility he entered for treatment.

Mr. Barengo described Section 1 as addressing the trauma centers, whereas Section 2 attempted to bring in all hospitals that treated trauma. Line 2 of page 3 included the language "acute life-threatening," and he viewed that as an attempt to define "trauma." A more refined definition of trauma was located in NRS 450B.105. Mr. Barengo suggested the addition of that definition to solve the problem. A physician treating any patient in any facility who met the definition of traumatic condition would be under the cap.

Assemblyman Oceguera voiced his opinion that because the language was so overly broad, it would invite unintended interpretations. He agreed there were established definitions of "trauma" in the NRS 450B.105 that would solve the issue.

In response to Assemblyman Oceguera, Mr. Barengo reminded the committee the use of that definition of trauma would bring into play the *Nevada Administrative Codes* (i.e., NAC 450B.798 and 450B.770) that dealt with the trauma issue.

Chairman Anderson called a committee recess with a request to reconvene at 4:30 p.m.

The Committee on Medical Malpractice Issues was called back to order at 4:47 p.m. Chairman Anderson announced the first order of business would be the continuation of testimony from Risa Lang, Committee Legal Counsel.

Ms. Lang offered to clarify the follow-up care provision of Section 1 of S.B. 2. The matter of "rebuttable presumption" was designed to assume that, in cases of medical malpractice, the event that caused the condition

occurred during the initial treatment. The $50,000 cap would not apply if it was due to an event that occurred during follow-up care. The burden would be on the plaintiff to prove otherwise.

Chairman Anderson summarized and used an example to illustrate. A patient was treated at the emergency room of a hospital and then admitted to the hospital to be stabilized. After 10 days of treatment, the patient was released to the care of his physician. In the course of being treated by his physician, he suffered a severe or permanent loss. As a result he hired an attorney. Chairman Anderson posed the question "Who has the burden to prove that his loss was not part of the original trauma and treatment?"

Risa Lang stated it created a "rebuttable presumption" that the medical condition was caused by the initial care. As such, the victim would be encumbered to then prove that it did not happen in the hospital, but rather it occurred in the physician's office during follow-up care. Ms. Lang called attention to line 27 and the language "a condition that arises during the follow-up care." As such, it was not that the condition arose during the course of the follow-up care, but the presumption would be the actual event that caused the condition happened at the time of initial treatment. The presumption would have to be overcome.

Chairman Anderson commented that Mr. Brower had dealt with the bill drafter and not with the hospital or administrators.

Assemblyman Brown asked if the language could cause the opposite situation and create a rebuttable presumption suggesting the physician caused the secondary condition. Ms. Lang responded the rebuttable presumption related to when the event occurred and not to the physician. Assemblyman Brown acknowledged that point; however, in his judgment, the language "the medical condition was caused by the care or assistance rendered" led him to believe it was the act of a physician. Ms. Lang clarified it was pursuant to subsection 1 or 2 and, as such, it would still have to be during the course of those events covered by those two subsections.

Assemblyman Brown reiterated "it did not go to the condition but to the actions of the physician or caregiver." Ms. Lang summarized by stating "the understanding was the condition that was causing the malpractice action was the cause of the caregiver assistance that took place while the physician was still covered under the cap. That is the correlation." Assemblyman Brown was uncertain if his question had been fully addressed. Ms. Lang agreed that she was unsure if her answer was adequate. Assemblyman Brown reiterated his concern that the language as drafted "the medical condition was caused by the care or assistance" might be saying it was the result of an action of a caregiver. It was his understanding the intent of the provision was to say "there is a rebuttable presumption that the secondary condition is really almost part of the first or result of the first condition – rather than the result of the care given by the physician."

Ms. Lang disagreed and stated it did go back to the physician. The rebuttable presumption arose when malpractice on the part of the physician could be demonstrated. Determining where in the course of events the malpractice occurred was a key point. In Ms. Lang's words "did it take place while the physician was entitled to the limited immunity or did it take place after that time when he was no longer covered under that $50,000 limited liability."

Assemblyman Oceguera concurred the language was subject to differing interpretation, especially in regard to the follow-up care. He recommended the intent be clear. Ms. Lang agreed that ambiguous language should be clarified. Chairman Anderson suggested Assemblyman Brown or Assemblyman Oceguera assist with the language in order to clarify intent. In his opinion, the intent was not to establish an indefinite time period.

Chairman Anderson returned to a hypothetical example of a patient who reported symptoms to his physician on a weekend. The physician advised him to report to the emergency room where the patient was subsequently treated and stabilized. Chairman Anderson asked if the $50,000 state sovereign immunity cap applied to that situation. Ms. Lang replied the cap applied anytime the conditions of subsection 1 or 2 were met. Under subsection 1, a patient with a "serious medical condition" who reported to a trauma center or an emergency room would be covered. Subsection 2 addressed the for-profit hospitals, and coverage depended upon whether or

not it was an "acute life-threatening medical condition." The $50,000 cap did not automatically cover follow-up care.

Continuing, Ms. Lang called the committee's attention to the language of subsection 4 that specified several conditions had to be met. The physician provided follow-up care, that care was directly related to the original medical condition, and the patient filed an action for malpractice based on the medical condition that arose during the course of the follow-up care. The provision of "rebuttable presumption" required the condition was caused by the care or assistance that was rendered under subsections 1 and 2. In summary, Ms. Lang stated it had to be connected to original treatment and not to unrelated subsequent events.

Chairman Anderson requested clarification on the subject of sovereign immunity. Conceptually, was the purpose to protect the state, the entity of government, and its citizens as a whole and not the individual citizen. Ms. Lang concurred. Chairman Anderson continued by stating it was designed to protect the "treasury of the people" and to ensure the stability of government. He added it was the reason for the low cap. He asked if the proposed legislation would "expand the protection of the people's treasury to private treasury." As such, it would raise the issue of constitutionality.

Ms. Lang replied there was no extension of sovereign immunity, but merely the use of similar language in the statute that waived sovereign immunity and allowed the government to be sued up to $50,000. The intent was not to create sovereign immunity for the named entities. It was designed to extend similar liability status. Chairman Anderson acknowledged the clarification and added the issues of sovereign immunity and constitutionality were always of concern.

Ms. Lang resumed testimony and addressed Sections 2-5 of S.B. 2, language that dealt with the caps on noneconomic damages. Section 2 was directory language and was identical in both S.B. 2 and A.B. 1. Section 3 defined economic damages, and the language was identical in both bills. Section 4 defined noneconomic damages, and the language was the same in both bills. Section 5 provided a $350,000 cap on noneconomic damages, and the language was amended by the Senate. In A.B. 1 there had been eight exceptions to the cap, whereas in S.B. 2 the list was reduced to two exceptions. Those exceptions were listed as gross malpractice and the situation when the court determined "by clear and convincing evidence at trial that an award in excess of $350,000 for noneconomic damages is justified because of exceptional circumstances." Ms. Lang clarified those two circumstances remained in the amended bill, however, the other six circumstances were eliminated.

In response to Chairman Anderson, Ms. Lang cited Section 5, page 5, lines 32 – 38. Referring to A.B. 1, Chairman Anderson asked if the removal of "death" and the "ability to have children" from the list of exceptions was appropriate. Were they not significant enough to be noted.

Ms. Lang declared that was a policy choice for the committee. In A.B. 1 there was a list of eight specific injuries determined to be significant in nature. In S.B. 2, the Senate chose to limit coverage to circumstances that related more to the actual act of gross malpractice or to judgments of the court. The latter provided for more court discretion.

Assemblyman Dini offered to explain the Senate's rationale for reducing the list. It was his understanding the Senate felt subsection 2(b) (i.e., court judgments) would cover all situations.

Chairman Anderson welcomed the next witnesses, Gerald Gillock, representing the Nevada Trial Lawyers Association (NTLA), and Dr. James Tate, a Las Vegas trauma surgeon.

Mr. Gillock stated he was present in the Senate when the language had been amended and passed. In his judgment, the elimination of specific exceptions invited questions and prolonged litigation in front of a court. It had been his experience the claims involving "death" and "loss of reproductive organs" were issues of high importance in the eyes of the jury as well as in the eyes of the person suffering the loss. Those cases often involved no large amount of economic loss; however, there was compelling need to compensate. The removal of the $350,000 cap in those cases was clearly not enough to compensate some victims. Mr. Gillock quoted the

language "in no event will the cap exceed the amount of their liability insurance so long as they carry $1 million in malpractice insurance coverage." For the remaining exceptions, such as organic brain damage, economic losses would be so large that the $1 million policy would be exceeded. It was conceivable there would be a better chance of convincing a judge "by clear and convincing evidence" that the individual was entitled to have the cap lifted. If the medical bills were $900,000, for example, the $100,000 remaining in the policy could be awarded by the judge. That would serve to keep the "exposure of the doctors down to their $1 million limit for noneconomic losses." Mr. Gillock emphasized it was important to understand that, in those instances, if the economic losses exceeded the $1 million policy limit, there would be no award for noneconomic losses.

In summary, Mr. Gillock stated when the bill was discussed and negotiated in the Senate, agreement was reached that the standard of "clear and convincing evidence" could be inserted; however, when the other exceptions were removed, it became onerous. He voiced concern that malpractice suits involving death or loss of reproductive organs would be subject to the whim of a judge who might be less than sympathetic to the losses. Awards could become very inconsistent across courtrooms. In his view, the amended legislation removed the discretion to award nonecomomic damages from the fact finder (i.e., the jury) and removed the matter from the arena of the courtroom. He encouraged the committee to seriously reconsider the elimination of the individual exceptions. The NTLA viewed it as jeopardizing the rights of citizens, especially in situations involving death and procreation.

Chairman Anderson added that his concern rested with the large, substantial part of the population.

Dr. James Tate, a trauma surgeon from Las Vegas and President of the West-Crear Medical Society, commenced testimony. He reflected on the examples of malpractice given in previous testimony and commented those were exactly the reasons behind most malpractice suits. Dr. Tate stated emphatically "If you are going to remove these injuries from the cap, there is no cap." In reviewing the list of specific exceptions in A.B. 1, Dr. Tate said the most onerous was 2c, "death of a parent, spouse, or child." In his view, the list of exceptions made no sense because most of those events were common and expected in the course of operating a trauma center. They were not outside the cap that was being created.

In response to a comment made by Mr. Gillock, Dr. Tate said it was not true that a case would only go to the policy limits. In actuality, a case would go to the policy limits and then the attorney could seek other assets from the accused. He cautioned the committee to be careful with exceptions (i.e., "giving something and then taking it all back").

Chairman Anderson requested clarification if the witness was opposed to all of the eight exceptions originally listed in A.B. 1 as well as the two exceptions listed in S.B. 2. Dr. Tate admitted he was reviewing the list contained in the Assembly bill. Chairman Anderson cautioned the witness that A.B. 1 was history, and he directed the witness to the Senate bill, page 5, lines 3 32 – 34. He reiterated his question as to why significant events, such as death and loss of reproductive ability, would not remain in the list.

Dr. Tate believed all of the circumstances would be covered under the umbrella of "gross malpractice." Chairman Anderson commented that it was an arguable question.

In reaction to a comment from Dr. Tate, Gerald Gillock interrupted the dialogue and asserted that he never saw gross malpractice or alleged negligence in 99.9 percent of his cases. Dr. Tate accepted the correction and continued with his testimony. Dr. Tate restated his opinion the issue was adequately covered by the language of the amended bill without making the list overly specific. Because of its inherent complexity, not all aspects of medicine could be legislated. Certain issues were subjective, such as the loss of reproductive ability, and might be judged to be less significant by some people.

Chairman Anderson summarized by saying that once a list was created it might never end.

Assemblywoman Parnell asked what the harm would be to include more specific cases in the list, for example, death. Dr. Tate posed a question. "Under what circumstances would you sue? If you lift the cap over death, you

might as well not have a cap in the trauma center. It doesn't make any sense because a lot of people will die in the trauma center."

Assemblywoman Parnell responded there appeared to be agreement that malpractice cases often dealt with issues not involving a death. She felt it was essential to be able to establish differences in circumstances that led to malpractice.

Assemblyman Manendo inquired about the frequency of lawsuits against the trauma center that were not based on genuine malpractice. Dr. Tate emphatically stated it happened too often, and he illustrated his point with an example. The case involved a reckless young man whose life was heroically saved by the trauma center surgeons. The victim suffered three cardiac arrests and ultimately overcame all odds for survival; however, he suffered renal failure and the loss of his legs, and he filed a lawsuit against everybody. Dr. Tate declared those situations happened all too frequently.

Chairman Anderson summarized and stated it appeared the case cited would not apply in the new situation because it would be a trauma. The exceptions would not apply to that scenario. Mr. Gillock interjected that the case would fall under the $50,000 cap. He was intimately familiar with that case, and it did not proceed against the doctors, but only against the market. In response to Chairman Anderson he stated "under the new statute, that definitely is true."

Dr. Don Havins, a physician and an attorney, commenced testimony and reflected on the proceedings in the Senate. He recalled the intent was to trust and empower the judge to make decisions based on clear and convincing evidence. That was preferred to a list enumerating specific medical conditions. Chairman Anderson acknowledged the insight.

Assemblyman Oceguera referred to the subsection covering "gross negligence" and voiced his agreement with the language in subsection 2(b) "clear and convincing evidence." He raised a question about "gross malpractice" and asked if the exceptions rose to the level of gross malpractice. Mr. Gillock responded "no" and explained, "the gross malpractice goes to the act and not the consequences of the act." Gross negligence was defined as a complete absence of any care. In his view, it was an almost impossible standard to meet. It was seldom seen in malpractice litigation. The issue was what the doctor did or did not do as opposed to what happened.

Assemblyman Brown commented if a judgment was rendered, any cap would be applied in the course of a courtroom verdict and judgment. In the examples of death or infertility, he asked if it was possible for the jury to make an award, and later the judge rendered a decision that the event was too significant to apply the cap. Mr. Gillock replied in the affirmative and stated in the given example, there would be no reminder to the jury that a cap did apply. The jury would be unaware of that fact when they rendered a decision. If a jury awarded, for example, $2.5 million in noneconomic damages, counter motions would be filed. The defense would file to invoke the cap of $350,000. A motion by the plaintiff would be filed to have the court determine there were extraordinary circumstances that warranted lifting of the cap. It would be argued under the standard of "clear and convincing evidence" as opposed to the normal standard of "a preponderance of the evidence." Mr. Gillock concluded by saying that was the procedure he anticipated under the new statute.

Chairman Anderson addressed Dr. James Tate and reminded him that his written testimony (Exhibit D) would be submitted for the record.

Dr. James Tate continued testimony and reviewed the highlights of his written testimony (Exhibit D). The West-Crear Medical Society was described as the county branch of the National Medical Association, a professional organization of African-American medical doctors. Dr. Tate revealed his organization had not been included in the negotiating team, despite letters expressing their interest and telephone calls offering to be included. Osteopaths were not included. Regarding the proposed legislation, Dr. Tate took exception to the phrase "what the doctors wanted" and declared "it was what a certain group of doctors wanted." He observed that no testimony had been received from trauma surgeons during the course of the current committee hearing.

Dr. Tate declared there were major problems with the bill. Regarding the issue of circumstances under which trial lawyers would accept limits, Dr. Tate explained his experience had been that trial lawyers would threaten to put a physician's personal assets at risk. He warned the committee to "either have a cap or do not have a cap." Too many exceptions would render the law meaningless.

Reflecting on testimony that suggested concern for the civil rights of plaintiffs, Dr. Tate commented if that were the case, there would be more trial lawyers taking police brutality cases and discrimination suits.

On the issue of the $50,000 cap at the UMC Trauma Center, Dr. Tate concluded it had been handled adequately. He offered to clarify several points from earlier testimony. The definition of a trauma patient was "intentional or unintentional wounding of a patient." In terms of how long the cap should apply, Dr. Tate suggested the language include "it applies until the patient has gone through his rehabilitative phase and is now discharged from further care." After that point, the patient should be on his own.

Regarding the list of medical conditions, Dr. Tate opined there were just too many variables in the practice of medicine, and not all situations could be legislated. On the subject of the $1 million—$3 million insurance liability requirement, Dr. Tate stated that would put a lot of the estimated 115 African- American doctors out of business in Nevada. Many had office-based practices, they seldom utilized hospital facilities, and therefore had little exposure to lawsuits; however, the trauma surgeons, in contrast, got sued often. If the bill was passed, Dr. Tate predicted a "monster had been created." His liability insurance premium was estimated to reach $160,000 if he was required to carry the $1 million—$3 million level of insurance coverage. His license to practice medicine was at stake for failure to comply under the proposed bill. Dr. Tate reminded the committee the bill language was the work of a very select group of physicians and did not represent the opinions of all doctors in Nevada.

Chairman Anderson commented the actions of the St. Paul Insurance Company had precipitated the crisis in Nevada. Some topics were long-standing issues in Nevada and were rightfully presented to the Nevada Legislature in previous sessions. On the topic of tort reform, Chairman Anderson characterized it as a familiar issue that traditionally lacked support in past legislative sessions. He admitted the pendulum was unlikely to swing widely to the other side, especially given the tests of constitutionality that would be invited. The worst kind of legislation, according to Chairman Anderson, was the kind that happened "under the gun." Indeed, the 120-day requirement for the legislative session created that working atmosphere. He admitted to being frustrated by the pressures of time limits. Chairman Anderson gratefully acknowledged the past input, personal sacrifice, and efforts of Dr. Tate, and stated that it had not gone unnoticed.

Dr. Michael Fischer approached the witness table to testify. Chairman Anderson explained he was calling witnesses in order of sign-in, and he would be called.

Dr. Denise Selleck Davis, representing the Nevada Osteopathic Medical Association (NOMA), read from written testimony. No copy was submitted for the record as requested by Chairman Anderson. Dr. Davis commenced her discussion with Section 18 of S.B. 2, language that specified "not less than $1 million of insurance per occurrence and not less than $3 million in the aggregate." In her view, that insurance obligation became a "licensure requirement."

Her association represented 200 of the 350 osteopathic physicians (DO's) practicing in Nevada. She echoed the testimony of Dr. Tate and stated osteopathic physicians were not invited to participate in the task force. Dr. Davis explained the primary specialty of her group was family practice, and many osteopaths practiced in rural areas. Through the years there had been an obvious trend by family practitioners to avoid hospital-based work because of the significant impact to their insurance premiums.

Dr. Davis voiced her objection to the inequity of requiring the same liability coverage for an invasive cardiac physician as for a one-doctor rural office. She cited the example of an elderly physician, Dr. Thomas McCleary of Reno, who operated a medical practice from his home. The new requirement for $1 million—$3 million

liability insurance would force the closure of his practice and require he surrender his license to practice medicine.

Dr. Davis explained that osteopathic physicians practiced under NRS 633. There was only one professional status in Nevada. "Either you were a full-fledged licensed physician or you were not." There were no categories for retired, disabled, inactive, or part-time practitioners. The burden of the insurance was predicted to force many of her associates out of practice. She illustrated her point with the example of a part-time physician at the Veterans Administration Hospital in Boulder City. He would be forced to give up his career. She reminded the committee the intent of the bill was to ensure that citizens had access to medical care and physicians. Dr. Davis called the proposal for uniform liability insurance "unreasonable," and the careers of many medical professionals were at risk.

Dr. Davis concluded her testimony by saying she had not met even one physician who was willing to practice without carrying liability insurance. It was not a viable option. Her fellow professionals deserved the right to practice.

Chairman Anderson requested the witness submit her written testimony to the secretary for inclusion in the record.

Assemblyman Brown asked if there was a median amount of insurance coverage for osteopaths (DO), especially in the rural areas. Dr. Davis explained that osteopaths practiced in a wide range of specialties, including family practice, anesthesiology, and psychiatry. Many of the trauma and emergency room physicians were DO's. As such, an estimate of a median amount was difficult.

Assemblywoman Ohrenschall shared a personal account of her family physician who was informed by his insurance company that his rates were being increased because he had not had any malpractice suits filed against him in recent years. As such, the actuarial tables predicted he was overdue for a malpractice event, and that made him high risk. She asked the witness if osteopaths were faced with that dilemma. Dr. Davis replied she had never had a physician complain about not being sued.

Chairman Anderson addressed the audience and invited any witness to come forward whose issues had not been covered.

Dr. Michael Fischer, ophthalmologist, offered to make a simple suggestion regarding insurance limits. "If a physician is covered at $1 million—$3 million, then he is protected by the cap. If the physician elects not to choose that kind of coverage, then he is not protected by the cap and therefore would not be tied to licensure." Dr. Fischer viewed it as a reasonable compromise.

The second issue raised by Dr. Fischer related to the list of exceptions to the cap. The condition of total blindness was not referenced anywhere in the language. He further suggested the condition first required a good definition, which historically was based in legal terminology. Dr. Fischer's final point was illustrated with an example of retinal surgeons whose patients sought treatment for retinal detachment. Dr. Fischer stated that, by definition, many of those patients were already legally blind (i.e., 20-200 vision or worse). If the surgeon elected not to repair the detachment, the eye usually became completely blind (i.e., no light). Inserting language into the law for "total blindness" without adequate definition could intimidate surgeons and interfere with decisions regarding surgery options. Chairman Anderson requested clarification if the witness was advocating an expansion of the list of medical exceptions. Dr. Fischer replied he was not in favor of expanding that list to include "total blindness." Chairman Anderson responded, "You want it limited on the back side." Dr. Fischer agreed.

Chairman Anderson acknowledged the input of the witness. The next order of business was Assemblyman Dini's earlier request for information on the general medical malpractice insurance rates for policies in the $500,000—$1.5 million range. He asked Mr. Anthony to comment.

Nicolas Anthony, Senior Research Analyst, shared some general information obtained from representatives of the insurance industry. A policy with liability limits of $500,000 and $1.5 million in the aggregate was generally 14 to 18 percent lower than the $1 million—$3 million coverage. For a general surgeon, Mr. Anthony stated the premium for a $1 million—$3 million policy was estimated at $84,000. A policy with $500,000—$1.5 million coverage was estimated at $68,000.

Chairman Anderson called for questions from his committee. He advised the committee of the floor meeting set for 7:00 p.m. Rather than adjourn the committee hearing, Chairman Anderson declared a recess and determined the committee could reconvene at the call of the Chair. In response to Assemblyman Marvel, Chairman Anderson explained the Senate had processed another piece of legislation that dealt with Ways and Means issues.

Chairman Anderson thanked all participants in the hearing. The meeting was recessed at 5:55 p.m.

Dr. John Haller, representing General and Vascular Associates, submitted handwritten testimony (Exhibit E) after the hearing had been recessed. The following was his verbatim testimony.

"Thank you, Mr. Chairman, for allowing me to voice my concerns. My name is John Haller. I am a general surgeon. I have practiced in Reno and Sparks for the past 14 years. These are my concerns:

#1 The news media has portrayed the current malpractice problem as a predominantly southern Nevada problem. It is not.

#2 I understand that testimony from trial lawyers yesterday indicated that Nevada's medical community is a 'C-minus' group. It is not.

#3 My malpractice premium has risen from $21,000 a year for 2 million—5 million coverage with no deductible to $57,000 a year for 1 million—3 million coverage and a $50,000 deductible.

#4 I have a new associate who has indicated to me that she may return to the Midwest if premiums remain high. In addition, 2 Reno obstetricians have quit delivering children over the past week and 1 gastroenterologist told me he would leave Nevada if current prices remain in effect and no tort reform is passed.

#5 My office has dismissed five employees to diminish overhead expenses due to our increased insurance costs.

#6 In the current climate of rising insurance premiums, declining reimbursement for surgical services from insurance companies and diminishing support from some hospitals, there will certainly be loss of access to health care by our indigent population.

#7 Requiring all licensed physicians in Nevada to have 1 million—3 million coverage will cause those semi-retired and retired physicians who provide assistance in surgery and who work as volunteers in senior care clinics, etc. to cease their valuable work.

#8 Institution of MICRA-like legislation and really meaningful tort reform is absolutely necessary. Any exceptions to a 'cap' will render that cap meaningless.

#9 The medical-legal screening panel should be retained to screen cases without merit.

Thank you. John L. Haller, M.D., FACS"

RESPECTFULLY SUBMITTED:

June Rigsby
Transcribing Secretary

APPROVED BY:

Assemblyman Bernie Anderson, Chairman

DATE:

-

Exhibit P

Exhibit P

In the Matter Of:

DIANE SCHWARTZ vs NO DAVID GARVEY

CV-C-17-439

JONATHAN BURROUGHS

March 15, 2021

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IN THE FOURTH JUDICIAL DISTRICT COURT

OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF ELKO

****

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

VS NO: CV-C-17-439

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

****

DEPOSITION OF JONATHAN BURROUGHS, MD

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

Now, I have seen the credentials material for Dr. Garvey, and he obviously looks like a fairly well qualified emergency physician. I saw those qualifications and those credentials. I didn't see any credentialing whatsoever or any authorization of Mr. Bartlett or Mr. Lyons to even touch a patient. I get it when a transport team comes, can they load the patient on a gurney? Sure they can. Can they assist the doctor? Sure they can.

But when you are intubating, that is the operating physician there. I don't know what your state's definition is of operating physician or surgeon. It is different in every state, and I have not been able to find that in your state, but when you are doing surgery on someone, you are now doing a clinical procedure that requires authorization right now. You need to be authorized, and if you don't, it can be a battery. It can be a battery, and it can be criminal charges in the whole thing, because you can't touch a

Exhibit Q

Exhibit Q

In the Matter Of:

Schwartz, Diane, et al. vs Garvey, David, M.D., et al.

BARRY AMOS RAY BARTLETT

December 20, 2019

Job Number: 581741

IN THE FOURTH JUDICIAL DISTRICT COURT

OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF ELKO

---o0o---

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

Plaintiff,

vs. Case No. CV-C-17-439

DAVID GARVEY, M.D., an individual; BARRY BARTLETT, et al., Dept. No. 1

Defendants.

_____/

VIDEOTAPED DEPOSITION OF BARRY AMOS RAY BARTLETT

DECEMBER 20, 2019

RENO, NEVADA

Reported by: JULIE ANN KERNAN, CCR #427, RPR

Job No. 581741

(Short break.)

VIDEOGRAPHER: We are going back on the video record. The time is approximately 10:18 a.m.

BY MS. MORALES:

Q How many intubations have you performed in your career as a paramedic?

A Approximately 1,500.

Q And that's a specific number. How'd you come up with that?

A I used to keep a record.

Q I'm sorry?

A Used to keep a record.

Q Do you still have that record?

A I do not.

Q And what was the purpose of keeping the record?

A Just have a record how many intubations I've done.

Q And when did you stop keeping record?

A Fifteen years ago.

Q Have you ever performed a cric procedure before?

A I have.

Q How many?

A Five.

Q How many had you performed before Mr. Schwartz?

A Four.

Exhibit R

Exhibit R

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the medical executive committee upon recommendation of the department or unless affirmatively renewed following the procedure as set forth in Section 5.5-2.

(c) Requirements for Focused Professional Performance Evaluation and monitoring, including but not limited to those in Section 5.3, shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges by the chief of staff after consultation with the departmental chair or the chair's designee.

(d) Temporary privileges may at any time be terminated by the chief of staff with the concurrence of the chair of the department or their designee, subject to prompt review by the medical executive committee. In such case, the appropriate department chair or, in the chair's absence, the chair of the medical executive committee shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of the replacement medical staff member.

(e) All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the medical staff.

5.6 EMERGENCY PRIVILEGES

In the case of an emergency, any member of the medical staff, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the medical staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the hospital.

5.6-1 DISASTER PRIVILEGES

The CEO, Chief of Staff, or his/her designee may grant disaster privileges when necessary to meet immediate patient needs after a Code Green (external disaster) or Code Yellow (internal disaster) has been activated. The CEO, Chief of Staff, or his/her designee is NOT required to grant disaster privileges to any individual and is expected to make such decisions on a case-by-case basis.

Those individuals granted disaster privileges will be assigned duties in accordance with the

Exhibit S

Exhibit S

CASE NO. CV-C-17-439

DEPT. NO. 1

IN THE FOURTH JUDICIAL DISTRICT COURT

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

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

Plaintiff,

V.

DAVID GARVEY, M.D., an individual; TEAM HEALTH HOLDINGS, INC., dba RUBY CREST EMERGENCY MEDICINE, PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH MEDICAL SERVICES, L.L.C., DOES 1 through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

/

ORDER DENYING PHC'S MOTION TO DISMISS AS TO THE FIRST CAUSE OF ACTION

On July 20, 2017, Defendant PHC-Elko, Inc., dba Northeastern Nevada Regional Hospital , (hereinafter "PHC") filed a Motion for Partial Dismissal of Plaintiff's Complaint (hereinafter "Motion"). Oral argument was held on the matter on September 6, 2018. Present at said hearing were Jennifer Morales, Esq., representing Diane Schwartz (hereinafter "Plaintiff"), Bianca Gonzales, Esq., representing Dr. David Garvey, M.D., Matthew Ballard, Esq., representing Reach Medical Services, L.L.C., and Zack Thompson, Esq., representing PHC-Elko, dba Northeastern Nevada Regional Hospital.

PHC moves for dismissal from Plaintiff's first cause of action for professional negligence/wrongful death and Plaintiff's fifth cause of action for loss of consortium. The parties agreed to forgo argument regarding the fifth cause of action pending the outcome of a motion to file a third amended complaint. With respect to PHC's motion to be dismissed from Plaintiff's first cause of action, PHC argues that Plaintiff's medical expert affidavit, which was attached to the Complaint as required by NRS 41A.071, does not implicate PHC in any liability because Dr. Garvey is an independent contractor. Plaintiff opposes PHC's Motion arguing that PHC has a non-delegable duty to employ skilled medical staff. Furthermore, Plaintiff contends that discovery is necessary to determine the professional and legal relationship between Dr. Garvey and PHC.

1. Although PHC does not owe a non-delegable duty to employ competent independent contractors, dismissal of PHC from Plaintiff's first cause of action prior to the discovery process is not justified.

In *Renown Health, Inc. v. Vanderford*, the Nevada Supreme Court rejected the opportunity to judicially create an absolute non-delegable duty of care for hospitals with regard to actions taken by independent contractor doctors. Renown Health, Inc. v. Vanderford, 235 P.3d 614, 615 (Nev. 2010). The general rule is that hospitals are not vicariously liable for the acts of independent contractor doctors. Id. at 616. The Nevada Supreme Court decided that imposition of an absolute non-delegable duty, which is akin to a strict liability scheme, would be a wide deviation from the general rule, and is better left up to the Nevada Legislature. Id.

The ostensible agency doctrine was adopted by the Nevada Supreme Court in *Schlotfeldt v. Charter Hospital of Las Vegas*, and functions as a narrow exception to the general rule against vicarious liability for hospitals. Schlotfeldt v. Charter Hosp., 112 Nev. 42, 48, 910 P.2d 271, 275 (1996). The ostensible agency doctrine applies when a patient goes to a hospital and the hospital selects the doctor that treats the patient. Id. In such cases, the doctor has apparent authority to bind the hospital because the patient may reasonably assume that a doctor selected by the hospital is an agent of the hospital. Id. Whether ostensible agency exists is a question of fact for the jury.

Here, PHC is correct when it asserts that it did not have a non-delegable duty of care to

Plaintiff for the actions of the hospital's independent contractors. However, even if Dr. Garvey was an independent contractor, PHC may still be liable under the ostensible agency doctrine. Plaintiff has set forth facts in the Complaint that give PHC adequate notice of the claim and the intention to sue PHC under a vicarious liability-type theory. *See* Complaint ¶¶ 36, 37. Plaintiff has complied with Nevada's notice pleading standard under NRCP 8(a). Dismissal at the pleading stage is only justified when the complaint has failed to allege facts establishing the elements of a claim, which, if true, would entitle a plaintiff to the relief sought. Buzz Stew, LLC v. City of N. Las Vegas, 124 Nev. 224, 228, 181 P.3d 670, 672 (2008). Thus, Plaintiff is entitled to maintain suit against PHC for professional negligence/wrongful death because the discovery process has not progressed to the point where the nature of the agency between Dr. Garvey and PHC can be determined.

Therefore, **IT IS HEREBY ORDERED** that PHC's Motion for Partial Dismissal of Plaintiff's Complaint with regard to Plaintiff's first cause of action is **DENIED**.

Dated this 8 day of May, 2019.

Nancy Porter

NANCY PORTER
DISTRICT JUDGE - DEPARTMENT 1

CERTIFICATE OF MAILING

Pursuant to NRCP 5(b), I hereby certify that I am an employee of the Fourth Judicial District Court, Department 1, and that on this 9th day of May, 2019, I deposited for mailing in the U.S. mail at Elko, Nevada, postage prepaid, a true file-stamped copy of the foregoing **ORDER PARTIALLY DENYING PHC'S MOTION TO DISMISS** addressed to:

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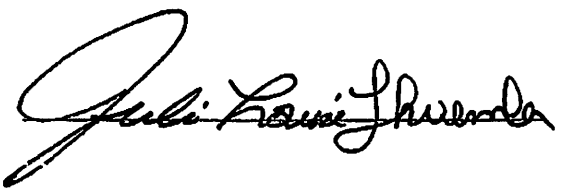

Case No: CV-C-17-439

Dept No. 1

IN THE FOURTH JUDICIAL DISTRICT COURT

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

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

Plaintiff,

V.

DAVID GARVEY, M.D., an individual; CRUM, STEFANKO, & JONES, LTD., dba RUBY CREST EMERGENCY MEDICINE, PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH MEDICAL SERVICES, L.L.C., DOES 1 through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.
_____/

ORDER ADDRESSING ALL PARTIES' MOTIONS FOR SUMMARY JUDGMENT

In anticipation of trial, all parties in this matter have filed their own separate motions for summary judgment as to particular claims in Plaintiff's Third Amended Complaint. Oral argument was heard on these motions, as well as on numerous motions in limine[1] on November 2, 3, and 4, 2021. The Court addresses summary judgment as to each claim below.

///

[1] These are addressed in a separate order.

1. Partial Summary Judgment as to the Applicability of the Trauma Cap Statute to all Claims (NNRH Only).

Under the Nevada Rules of Civil Procedure, the Court shall grant summary judgment when there are no genuine issues of material fact as to a given claim or defense. NRCP 56. A party moving for summary judgment must support its assertion that there are no genuine issues of material fact by referring to particular materials in the record, or by showing that the materials cited by an opposing party do not establish the presence or absence of a genuine issue. NRCP 56(c). When ruling on a motion for summary judgment, the Court may consider all materials in the record, not just those cited in the parties' briefs. NRCP 56(c)(3). Although the Court reviews the pleadings and other proof in the light most favorable to the non-moving party, the non-moving party must still show "by affidavit or otherwise [...] specific facts demonstrating the existence of a genuine issue for trial or have summary judgment entered against him." Wood v. Safeway, Inc., 121 Nev 724, 729-731 (2005).

In this motion, Defendant PHC-Elko dba Northeastern Nevada Regional Hospital ("NNRH") claims that there is no genuine issue of material fact as to the applicability of the "trauma cap" statute, NRS 41.503. NRS 41.503 states that a covered hospital, hospital employee, physician, or dentist ("medical professional[2]"), who

> in good faith renders care or assistance necessitated by a traumatic injury demanding immediate medical attention, for which the patient enters the hospital through its emergency room or trauma center[3], may not be held liable for more than $50,000 in civil damages, exclusive of interest computed from the date of judgment, to or for the benefit of any claimant arising out of any act or omission in rendering that care or assistance if the care or assistance is rendered in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct.
> NRS 41.503(1).

///

///

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[2]All parties agree that Defendant NNRH meets the definition of a covered hospital under NRS 41.503(1).

[3]All parties agree that Decedent Douglas Schwartz entered the hospital through its emergency room.

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

For purposes of NRS 41.503, a traumatic injury is defined as "any acute injury which, according to standardized criteria for triage in the field, involves a significant risk of death or the precipitation of complications or disabilities,"[4] and "reckless, willful or wanton conduct" is defined as

> 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.
> NRS 41.503(4)(a).

Putting all of the above together, the Court would need to find all of the following as a matter of law before it could grant summary judgment to Defendant NNRH as to the application of the trauma cap to Plaintiff's claims: that NNRH, (1) in good faith and in a manner not amounting to (1)(a) gross negligence or (1)(b) reckless, willful, or wanton conduct; (2) rendered care or assistance necessitated by (3) a traumatic injury which demanded (4) immediate medical attention. The Court would also have to find that NNRH's act (5) did not occur after the decedent was (5)(a) stabilized and (5)(b) capable of receiving treatment as a non-emergency patient or that NNRH's act (6) was unrelated to the original traumatic injury.

Despite Defendant NNRH's statements to the contrary, there still remain serious questions about the nature of Decedent's injuries at the time he arrived at the hospital and whether he was stabilized before the attempted cricothyrotomies and intubations that led to him aspirating his vomit and dying. NNRH points to the many uses of the word "trauma" in the discovery of this case. It also points to Dr. Garvey's deposition in which he stated that Decedent suffered from a flail chest, which is known to be a life-threatening injury.

---

[4] NRS41.503(4)(b).

Plaintiff relies on the reports of Drs. Burroughs and Womack, who state, respectively, that Decedent would not have died from his injuries from the car accident alone and that Decedent did not have a flail chest when he arrived at the hospital.

The Court is not convinced that the use of the word "trauma" in the parties' medical experts' reports equates to a traumatic injury as used by NRS 41.503. NRS 41.503 requires that the injury create a significant risk of death or the precipitation of complications or disabilities for it to be considered a traumatic injury for the purpose of applying the trauma cap. While Dr. Garvey indicates that Decedent suffered from a flail chest which created a significant risk of death, Drs. Burroughs and Womack state that Decedent's injury was not a flail chest and, whatever the nature of his pre-hospital injury, it did not create a significant risk of death, complications, or disabilities. The Court therefore DENIES Defendant NNRH's motion for partial summary judgment as to the applicability of the trauma cap statute to all claims[5].

2. <u>Partial Summary Judgment as to Individual Claims.</u>

A. Claim 1: Professional Negligence (NNRH, Plaintiff, and Ruby Crest)

1. NNRH and Plaintiff

Defendant NNRH argues that the Court should grant summary judgment in its favor on Claim 1 because Plaintiff misstates the law when she states that Defendant NNRH owed a non-delegable duty of care to its patients. As there is no such non-delegable duty, NNRH argues that the Court should grant summary judgment to it on this Claim.

Plaintiff states that NNRH had a duty of care to its patients that it violated by allowing REACH Air Medical Services, LLC ("REACH") personnel who did not have NNRH hospital privileges to render patient care within NNRH. Plaintiff argues that this breach of duty is so obvious that the Court should find it

---

[5]To make clear both this current order as well as the Court's previous orders denying partial summary judgment, the Court has not determined whether Defendant NNRH has met any of the other requirements for the NRS 41.503 trauma cap to apply. The Court simply finds that there remains at least one genuine issue of material fact as to whether Decedent suffered from a traumatic injury as defined by NRS 41.503(4)(b) before he arrived at NNRH.

sounds as ordinary negligence, not professional negligence, and grant summary judgment on Claim 1 in her favor. If the Court finds that this claim does sound in professional negligence, however, Plaintiff argues that the Court must allow the question of NNRH's negligence in allowing REACH to work on Douglas Schwartz (hereafter,"Schwartz" or "Decedent") inside NNRH to be presented to the jury.

The Court finds that Plaintiff's allegations relating to NNRH allowing non-credentialed REACH staff to work on Mr. Schwartz do not appear anywhere in the Complaint. The only language in Claim 1 addressing NNRH states that NNRH "owed Mr. Schwartz a non-delegable duty to employ medical staff including Dr. GARVEY to have adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances." Third Am. Complaint, p. 11, §52. Pursuant to Renown Health Inc. v. Vanderford, however, "there is no legal or policy basis for imposing an absolute nondelegable [sic] duty on" hospitals in Nevada. Renown, 235 P3d 614, 616 (Nev 2010). Further, this Court has previously advised Plaintiff that Nevada does not recognize a theory of non-delegable duty on hospitals in its May 2019 Order denying NNRH partial summary judgment. Plaintiff has amended and attempted to amend her Complaint several times since 2019. If she had wanted to include a specific claim against NNRH alleging that it has a specific duty to prevent persons who are not contracted with it from providing medical services inside NNRH, she had multiple opportunities to do so. Defendant NNRH's motion for partial summary judgment as to Claim 1 is therefore GRANTED. For the same reasons, Plaintiff's motion for partial summary judgment as to ordinary negligence is therefore DENIED.

2. Ruby Crest

Defendant Crum, Stefanko & Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest") argues that it too should be granted summary judgment as to Claim 1. Ruby Crest states that Plaintiff does not support her statement in Claim 1 that Ruby Crest was professionally negligent with any specific factual allegations. Plaintiff argues that she is entitled to argue that Ruby Crest was both vicariously liable and directly liable for Decedent's death, and that there remain genuine issues of material fact as to both theories

of liability.

Plaintiff is entirely correct that she is free to pursue claims against Ruby Crest for both vicarious liability for the acts of Dr. Garvey, and for direct liability for negligently training and/or supervising and/or hiring Dr. Garvey. Plaintiff has made those claims in Claim 2 (vicarious liability) and Claim 3 (negligent training, supervision, and hiring) of her Complaint. Claim 1 of Plaintiff's Complaint does not address Ruby Crest at all outside of the title, however. Plaintiff has therefore failed to show that there is a genuine issue of material fact about whether Ruby Crest committed professional negligence. Summary judgment as to Claim 1 is therefore also GRANTED to Ruby Crest.

B. Claim 2: Vicarious Liability, Corporate Negligence, and Ostensible Agency (NNRH, Plaintiff, Ruby Crest, and REACH Air).

1. NNRH, Plaintiff

Defendant NNRH next asks the Court to grant it summary judgment as to Claim 2, stating that there is no genuine issue of material fact regarding either Plaintiff's negligent credentialing claim, which NNRH maintains Nevada does not recognize, or Plaintiff's ostensible agency claim, which NNRH maintains is not supported by the facts. also argues that there are no genuine issues of material fact regarding the ostensible agency theory, but for the contrary reason: while NNRH argues that Garvey was clearly not presented to Schwartz as the agent of the hospital, Plaintiff argues that the consent form given to Plaintiff was ambiguous when it stated that "most or all" of the physicians at NNRH were independent contractors, and that Schwartz therefore reasonably believed he was being treated by a hospital employee.

a. Negligent Credentialing Claim.

As a preliminary matter, negligent credentialing is not coextensive with corporate negligence. Corporate negligence is a catch-all theory of liability for hospitals which replaced hospitals' previous immunity from liability as charities. Moore v. Board of Trustees, 88 Nev 207, 212 (1972) (citing Darling v. Charleston Community Memorial Hosp., 211 NE 2d 253 (Ill 1965)). Corporate liability theory posited that hospitals were behaving more like corporations than charities and could therefore be held liable for

their negligent acts in some circumstances. Id. Corporate negligence is thus not a separate tort but an acknowledgment of how society's view of hospitals has changed from being a purely charitable enterprise to something closer to a business.

The tort of negligent credentialing tumbles out of this change in conception. Negligent credentialing theory imposes liability on a hospital for failing to exercise reasonable care in granting hospital credentials or privileges to a physician. Rieder v. Segal, 959 NW2d 423, 429 (Iowa 2021). The Court thus does not address whether to grant summary judgment on the broad theory of liability that is corporate negligence but rather on whether to grant summary judgment on the specific tort of negligent credentialing.

Although it is not clear whether Nevada recognizes negligent credentialing claims, the basic elements of such a claim are easily identified:

> Generally, a plaintiff must show three things to establish a negligent credentialing claim:(1) the hospital failed to exercise reasonable care in granting privileges to the physician to practice medicine, or their specialty, at the hospital; (2) the physician breached the standard of care that a reasonably competent and skilled health care professional, with a similar background and in the same medical community, would have provided while rendering medical care and treatment to the plaintiff; and (3) the hospital's failure to exercise due care in permitting their physician to practice at the facility was the proximate cause of the plaintiff's injuries.
> Rieder v. Segal, 959 NW 2d 423, 429 (Iowa 2021).

A plaintiff would therefore need to be able to show what it is that made the granting of credentials to that particular physician unreasonable; i.e., what the hospital's duty of care in granting credentials to a physician actually entails. "All courts that have looked at the question have concluded that expert testimony is necessary to establish the standard of care owed by a hospital, or whether the hospital has been negligent." Benjamin J. Vernia, Tort Claim for Negligent Credentialing of Physician, 98 ALR 5th 533, 553 (2002) (internal citation omitted). Where expert testimony is needed to establish the standard of care, the case sounds in professional negligence; where the case sounds in professional negligence, it requires the attachment of an affidavit by a medical expert. NRS 41A.071. Plaintiff did not attach an affidavit identifying "factually a specific act or acts of alleged negligence" that NNRH committed in credentialing Dr. Garvey. NRS 41A.071(4). Therefore, even taking the corporate negligence claim as alleged and assuming *arguendo* that Nevada does recognize the tort of negligent credentialing, this claim still fails and

must be dismissed for failure to comply with the requirements of NRS 41A.071. For all these reasons, then, NNRH's motion for summary judgment as to the corporate negligence claim of Count 2 is GRANTED.

b. Ostensible Agency Theory

As to the ostensible agency theory on which Plaintiff's vicarious liability claim is based, the Court finds that there remain genuine issues about whether Dr. Garvey was the ostensible agent of NNRH. "The ostensible agency theory applies when a patient comes to a hospital and the hospital selects a doctor to serve the patient. The doctor has apparent authority to bind the hospital because a patient may reasonably assume that a doctor selected by the hospital is an agent of the hospital." Schlotfeldt v. Charter Hosp., 112 Nev 42, 48 (1996). Schlotfeldt provides a non-exhaustive list of questions of fact to consider when determining whether an ostensible agency relationship exists between a doctor and hospital: "[t]ypical questions of fact for the jury include (1) whether a patient entrusted herself to the hospital, (2) whether the hospital selected the doctor to serve the patient, (3) whether a patient reasonably believed the doctor was an employee or agent of the hospital, and (4) whether the patient was put on notice that a doctor was an independent contractor." Id. In acknowledging the applicability of the ostensible agency doctrine to the question of whether a hospital is vicariously liable for an independent contractor doctor's professional negligence, Schlotfeldt cites to Stewart v. Midani, a case from the United States District Court for the Northern District of Georgia. After itself examining ostensible agency doctrine caselaw from across the country, the Stewart court concluded that "[t]he critical question is whether the hospital nurtures the patient's belief (if even by mere acquiescence) that the doctor is the hospital's agent." Stewart v. Midani, 525 FSupp 843, 853 (ND Ga 1981).

Plaintiff and Defendant NNRH disagree about all of the Schlotfeldt factors, save for the first one: both parties appear to agree that Schwartz did not choose NNRH; rather, the ambulance that transported him took him to the only existing hospital in Elko. Plaintiff argues that NNRH, not Schwartz, selected Dr. Garvey to care for him; that Schwartz reasonably believed that Dr. Garvey was employed by the hospital because of the ambiguity of NNRH's independent contractor notice; and that Schwartz was never independently told that Dr. Garvey was actually an independent contractor, not an employee, of NNRH.

Defendant NNRH states that Ruby Crest, not NNRH, selected Dr. Garvey to work at NNRH the night that Schwartz arrived at the hospital. NNRH argues that the independent contractor notice which Plaintiff signed was clear and unambiguous in communicating to the Schwartzes that Dr. Garvey was an independent contractor and not a hospital employee. NNRH thus argues that Schwartz was aware of Garvey's employment status at the time of his death.

The Court need not address all Schlotfeldt factors; summary judgment cannot be granted if a genuine issue of material fact exists as to any one of them. The Court finds that there remain genuine issues of material fact as to whether NNRH put Schwartz and not just Plaintiff on notice that Dr. Garvey was not a hospital employee, and whether Schwartz reasonably believed that Dr. Garvey was a hospital employee. Even if the jury believes that Schwartz saw NNRH's notice, about which there is also a genuine issue of fact, a reasonable juror could find that the notice's use of "most or all" language was vague and that it could be interpreted differently by reasonable patients. Alternately, a reasonable juror could find that the language in the notice was actually sufficient to put Schwartz on notice that Dr. Garvey was an independent contractor.

As the Court thus finds that genuine issues of material fact remain as to whether Plaintiff can establish an ostensible agency relationship between NNRH and Dr. Garvey, Defendant NNRH's motion for partial summary judgment as to ostensible agency is DENIED. Plaintiff's motion for partial summary judgment as to ostensible agency is also DENIED for the same reasons.

2. Ruby Crest

Defendant Ruby Crest argues that the Court should grant it summary judgment as to the direct corporate negligence portion of Claim 2. Ruby Crest argues that this claim sounds in professional, not ordinary, negligence; it therefore needed to have a medical expert affidavit attached to support it, which was not done. Plaintiff argues that she did not need to attach a medical expert affidavit because this claim sounds in ordinary, rather than professional, negligence. Plaintiff also argues that Ruby Crest was negligent by knowingly allowing uncredentialed persons from REACH Air Services to routinely administer clinical

services to Ruby Crest's emergency room patients in contravention to NNRH bylaws. At oral argument, Plaintiff argued that Ruby Crest allowing uncredentialed persons to work in the NNRH emergency room is a violation of the services contract that Ruby Crest has with NNRH.

As stated in Section II(b)(i)(a), supra, the tort of negligent credentialing sounds in professional negligence and therefore requires expert testimony to establish the standard of care owed by the hospital (or in this case, the Ruby Crest medical clinic) when credentialing physicians. Plaintiff has not provided any medical expert reports to support this allegation. Ruby Crest's motion for summary judgment as to Claim 2 is thus GRANTED.

In Plaintiff's opposition to Ruby Crest's motion for summary judgment, as well as in oral argument, Plaintiff routinely describes Claim 2 as being based in a breach of contract between NNRH and Ruby Crest. Plaintiff states that Ruby Crest had an obligation under its contract with NNRH not to allow uncredentialed persons, such as REACH staff, to perform medical services in the NNRH emergency room. This description of Plaintiff's Claim 2 falls short for two reasons, the first of which is that it appears nowhere in the Third Amended Complaint. Claim 2 states that Defendants were negligent when they determined that Dr. Garvey should be granted credentials; it says nothing about knowingly allowing persons who had never been granted credentials to come into the emergency room.

The second reason this argument falls flat is because, as Plaintiff has not alleged that she or her husband were parties to the contract at issue, the only way for her to have standing to sue for a breach of contract between two other parties would be for her to assert that she was a third-party beneficiary of that contract. Boesiger v. Desert Appraisals, Ltd. Liab. Co., 444 P3d 436, 441 (Nev 2019). To do so, Plaintiff would have needed to show "(1) a clear intent to benefit the third party, and (2) the third party's foreseeable reliance on the agreement." Id. Although Plaintiff could perhaps have made a colorable argument as to the first prong, as one reason for not allowing persons to work in a department for which they have not been credentialed is for patient safety, she has not even begun to allege any facts which would support the second prong. There is nothing to show that it was foreseeable to either NNRH or Ruby Crest that a patient would be aware of and then rely on this inter-corporate contract when choosing a doctor or hospital.

Therefore, even assuming *arguendo* that Plaintiff could contort her corporate negligence claim into one for breach of a contract for a third-party beneficiary, and that she could somehow do so without amending her Complaint for the fifth time, and then taking all facts before the Court in the light most favorable to Plaintiff, the Court would still be constrained to find that there are no genuine issues of material fact that would allow the corporate negligence portion of Claim 2 to proceed against Ruby Crest. As stated above, then, Ruby Crest's motion for summary judgment as to corporate negligence is GRANTED.

3. REACH Air

Defendant REACH Air seeks summary judgment as to the vicarious liability portion of Claim 2, arguing that, while it is liable for the acts of its own employees, it is not liable for the acts of the other Defendants. Plaintiff states that she is not alleging that REACH is directly liable for the acts of the other Defendants; rather, she is alleging that REACH is jointly and severally liable for the actions of NNRH and Dr. Garvey under NRS 41.141(5).

NRS 41.141 addresses comparative negligence and the liability of multiple defendants. Specifically, it states that, in a case with multiple defendants, each defendant is only severally liable to the plaintiff based on the percentage of negligence attributable to them. NRS 41.141(4). It then states that defendants are both jointly and severally liable in the following types of claims: strict liability, intentional torts, toxic torts, concerted acts of defendants, and products liability claims. NRS 41.141(5). NRS 41.141(6) specifically excludes "negligent acts committed by providers of health care while working together to provide treatment to a patient" from the definition of concerted acts of defendants. Claim 2, paragraph 64, of Plaintiff's Third Amended Complaint alleges that "[t]he Defendants were the employers, masters, principals, and/or ostensible agents of each other, the remaining Defendant, and other employees, agents, independent contractors and/or representatives who negligently failed through their credentialing and re-credentialing process to employ and or [sic] grant privileges to an emergency room physician with adequate training". Nothing in the record indicates that REACH or its employees or independent contractors was in any way involved with the credentialing or re-credentialing process for Dr. Garvey. Further, even if REACH were

somehow involved in and liable for the credentialing or re-credentialing of Dr. Garvey, the Court finds that NRS 41.141(5-6) specifically indicate that this liability would be several, not joint. The Court finds that there are no genuine issues of material fact regarding REACH Air's vicarious and joint and several liability for the acts of NNRH and Dr. Garvey. REACH Air's motion for partial summary judgment as to Claim 2 is therefore GRANTED.

C. Claim 3: Negligent Hiring, Training, and Supervision (NNRH and Ruby Crest[6])

1. Ruby Crest

Defendant Ruby Crest argues that it too is entitled to summary judgment as to the entirety of Plaintiff's Claim 3. Ruby Crest alleges that the claims of negligent hiring, training, and supervision all stem from Dr. Garvey's professional negligence in treating Decedent; therefore, these claims are also professional negligence claims and need to be supported by a NRS 41A.071 medical expert affidavit, which Plaintiff did not provide. Plaintiff argues that Ruby Crest knowingly allowing uncredentialed persons to assist it in the NNRH emergency room falls under the common knowledge exception to professional negligence; this claim therefore actually sounds under ordinary negligence and does not require the support of a medical expert affidavit.

Claims for negligent hiring, training, and supervision in a medical context may sound in either ordinary negligence or professional negligence. "[T]he threshold issue is whether [the plaintiff's] negligent hiring, training, and supervision claim is truly an independent tort or whether it is related and interdependent on the underlying negligence of [the defendant]." Zhang v. Barnes, 132 Nev 1049 (2016). When "a negligent hiring, training, and supervision claim is based upon the underlying negligent medical treatment, the liability is coextensive" and the torts sound in professional negligence. Id.

Here, the allegations of negligent hiring, training, and supervision stem from the death of Schwartz,

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[6]Although REACH asks for summary judgment as to this claim also, REACH never actually addresses negligent hiring, training, or supervision anywhere in the body of its motion. Therefore, the Court finds that REACH has abandoned this argument. "It is appellant's responsibility to present relevant authority and cogent argument; issues not so presented need not be addressed by this court." Maresca v. State, 103 Nev 669, 673 (1987).

which Plaintiff argues was caused by the professional negligence of Defendants. The negligent hiring, training, and supervision of Defendants, their employees and/or independent contractors is thus "based upon the underlying negligent medical treatment;" this claim is therefore a professional negligence claim which needs a medical expert affidavit attached. As no affidavit was attached to support the allegations that Ruby Crest negligently hired, trained, or supervised anyone, Ruby Crest's motion for summary judgment on Claim 3 is GRANTED.

2. NNRH

Defendant NNRH next asks for summary judgment as to the entirety of Plaintiff's third claim for relief, arguing that, because no actual employee of NNRH is alleged to have been professionally negligent, NNRH could not have negligently hired, trained, or supervised anyone. This is a misreading of the law. Pursuant to San Juan v. PSC Industrial Outsourcing, a person or organization that hires an independent contractor can be directly liable for the torts of its independent contractor if the plaintiff can show "control, negligent hiring, or other basis for direct liability." San Juan v. PSC Indus. Outsourcing, 126 Nev 355, 363 (2010). Therefore, the mere lack of a formalized employment agreement between NNRH and Dr. Garvey does not rule out the possibility that NNRH could be directly liable for any torts caused by Dr. Garvey.

This does not end the Court's analysis, however, as NNRH's reply brief in support of its Motion for Partial Summary Judgment does address a meritorious argument: that the negligent supervision, training, and hiring claims pled against NNRH fail as they are professional negligence claims unsupported by an NRS 41A.071 medical expert affidavit. For the same reasons as stated in the Court's order addressing Ruby Crest's identical argument in Section II(c)(i) supra, Defendant NNRH's motion for summary judgment as to Claim 3 is GRANTED.

D. Claims 6, 7, 8: Intentional Torts and Punitive Damages (REACH Air)

1. Intentional Tort Elements, including Informed Consent

REACH next asks for partial summary judgment on Claims 6, 7, and 8 because it believes that Plaintiff cannot prove the elements of any of the intentional torts she alleges. REACH also argues that Schwartz provided informed consent, the scope of which allowed for REACH personnel to touch him.

REACH therefore argues that summary judgment must be granted as to all intentional tort counts as no unlawful touching occurred. Plaintiff argues that she has provided factual allegations to support each element of her intentional tort claims, and that, because REACH personnel have stated they never believed that they were in a provider-patient relationship with Schwartz at all, the analysis is not whether REACH's actions were within the scope of consent given, but rather, whether Schwartz gave any consent at all. Plaintiff argues that this consent question, as well as the factual allegations for each tort, must be presented to the jury.

The Court already addressed both the "factual elements" and "consent" questions in its September 29, 2021, Order denying REACH Air's Motion to Dismiss. The Court therefore declines to reconsider its previous ruling and DENIES REACH's request to grant summary judgment as to the entirety of Claims 6-8.

2. Punitive Damages

REACH next asks the Court to grant partial summary judgment on the issue of punitive damages for Claims 6-8 because it believes that Plaintiff cannot prove the requirements needed to impose those damages. In order to impose punitive damages, Plaintiff must prove "by clear and convincing evidence that the defendant has been guilty of oppression, fraud or malice, express or implied." NRS 42.005. A corporate employer can be vicariously liable for punitive damages if a) it had advance knowledge that its employee was unfit for employment and employed that employee with a conscious disregard of the rights or safety of others; b) it expressly authorized or ratified the wrongful act of the employee for which damages are awarded; or c) it is personally guilty of express or implied oppression, fraud, or malice. NRS 42.007. Plaintiff argues that REACH ratified its personnel's conduct when it sent Plaintiff a bill for flight services never actually rendered to her husband.

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For the trier of fact to find that REACH ratified its employees' conduct,

> the authorization, ratification, or oppression, fraud, or malice must be accomplished by an "officer, director, or managing agent of the corporation who was expressly authorized to direct or ratify the employee's conduct." Although NRS 42.007 fails to define a managing agent, [the Nevada Supreme Court] previously have recognized that determining an individual's managerial capacity depends on "what the individual is authorized to do by the principal and whether the agent has the discretion as to what is done and how it is done."
> Countrywide Home Loans, Inc. v. Thitchener, 124 Nev 725, 747 (2008) (citing Smith's Food & Drug Ctrs. v. Bellegarde, 114 Nev 602, 611 (1998)).

Plaintiff has not alleged that any specific person from REACH's billing department ratified the actions of REACH personnel Barry Bartlett and Ronny Lyons at NNRH. Plaintiff instead alleges that the billing department as an entity did the ratification. The Court cannot find that an "officer, director, or other managing agent" ratified REACH's conduct when no such officer, director, or managing agent is identified. Even if such a person were identified, it is unlikely that the Court could find ratification because the person who sent Plaintiff the incorrect bill would also need to be someone with some level of discretion over their actions. It seems highly unlikely that the individuals tasked with preparing and mailing REACH's invoices would have any kind of discretion in what bills they send, and for how much. As Plaintiff has not alleged that an officer, director, or other managing agent ratified its personnel's actions at NNRH, there is no genuine issue of material fact to present to the jury for the imposition of punitive damages. REACH's Motion for Partial Summary Judgment is GRANTED as to punitive damages.

3. Application of NRS 41A to all Remaining Claims against NNRH.

NNRH lastly asks the Court to find that all remaining claims against it are professional negligence claims subject to the requirements and regulations of NRS 41A. Plaintiff argues that her claims for ostensible agency, corporate negligence, vicarious liability, negligent hiring, negligent training, and negligent supervision are all capable of being understood by a lay juror without expert testimony; they are therefore claims for ordinary negligence, not professional negligence. Plaintiff therefore asks for summary judgment in her favor as to the non-applicability of NRS 41A to those claims.

As stated in Section II(c)(i), *supra*,"the threshold issue is whether [the plaintiff's] negligent hiring,

training, and supervision claim is truly an independent tort or whether it is related and interdependent on the underlying negligence of [the defendant]." Zhang v. Barnes, 132 Nev 1049 (2016). When "a negligent hiring, training, and supervision claim is based upon the underlying negligent medical treatment, the liability is coextensive" and the torts sound in professional negligence. Id. As stated in the 1994 Texas Court of Appeals case, Duncanville Diagnostic Center, Inc. v. Atlantic Lloyd's Insurance Company of Texas, referenced in Zhang: "[the decedent's] death could not have resulted from the negligent hiring, training, and supervision or from the negligent failure to institute adequate policies and procedures without the negligent rendering of professional medical services." Duncanville Diagnostic Ctr. v. Atl. Lloyd's Ins. Co., 875 SW2d 788, 791 (Tex App 1994). The Duncanville court thus found that the negligent hiring, training, and supervision claims sounded in professional negligence.

Here, all of Plaintiff's claims stem from the underlying allegedly negligent medical treatment of Schwartz. As in Duncanville, then, there is no genuine issue of material fact as to whether all of Plaintiff's claims sound in professional negligence: they do. All of Plaintiff's remaining claims are therefore beholden to the restrictions imposed on all professional negligence claims under NRS 41A. NNRH's Motion for Partial Summary Judgment as to the application of NRS 41A to all remaining claims is therefore GRANTED.

IT IS SO ORDERED this 12th day of July, 2022.

KRISTON N. HILL
DISTRICT JUDGE - DEPARTMENT 1

CERTIFICATE OF MAILING

Pursuant to NRCP 5(b), I hereby certify that I am an employee of the Fourth Judicial District Court, Department 1, and that on this 14th day of July, 2022, I deposited for mailing in the U.S. mail at Elko, Nevada, postage prepaid, a true file-stamped copy of the foregoing order addressed to:

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