Case Nos. 79658, 80113, 80968

In the Supreme Court of Nevada

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VALLEY HEALTH SYSTEM, LLC, d/b/a CENTENNIAL HILLS HOSPITAL MEDICAL CENTER,

Appellant,

vs.

DWAYNE ANTHONY MURRAY, individually, as an heir, as guardian and natural parent of BROOKLYN LYSANDRA MURRAY, and as special administrator of the Estate of LAQUINTA ROSETTE WHITLEY-MURRAY,

Respondent.

APPEAL

from the Eighth Judicial District Court, Clark County
The Honorable JACQUELINE M. BLUTH, District Judge
District Court Case No. A699586, consolidated with Case No. A699612

RESPONDENT'S ANSWERING BRIEF

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Docket 79658 Document 2021-30773

NRAP 26.1 DISCLOSURE

The undersigned counsel of record certifies that the following are persons and entities as described in NRAP 26.1(a) and must be disclosed. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

Dwayne Anthony Murray is an individual.

David O. Creasy, Danial Laird, and Ivy Gage of The Gage Law Firm, PLLC represented Murray in the district court.

Mr. Creasy, together with Daniel F. Polsenberg and Abraham G. Smith of Lewis Roca Rothgerber Christie, LLP, represent Murray before this Court.

Dated this 25th day of October, 2021.

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JURISDICTION

Respondent Dwayne Anthony Murray, individually, as an heir, as guardian and natural parent of Brooklyn Lysandra Murray, and as special administrator of the Estate of Laquinta Rosette Whitley-Murray ("Murray") does not dispute this Court's jurisdiction.

ROUTING STATEMENT

Murray agrees that the Supreme Court should retain this case. Appellant's theory that NRS chapter 41A applies not just to acts of professional negligence, but to intentional breaches of a hospital's fiduciary duties—based on a profit motive rather than any exercise of medical judgment—has never been adopted. Such an expansion of NRS chapter 41A's reach beyond the statutory text could be contemplated, if at all, only by the Supreme Court. NRAP 17(a)(12).

PRINCIPAL ISSUES PRESENTED

1. Did the district court correctly hold that hospitals owe a fiduciary duty to their patients separate from liability for professional negligence and that Murray properly pleaded a claim for breach of fiduciary duty?

2. Did the district court correctly determine that Murray's breach of fiduciary duty claim could be supported by the medication administration policy adopted by appellant Valley Health System, LLC, d/b/a Centennial Hills Hospital Medical Center ("Centennial") because it was not based on medical judgment, diagnosis, or treatment?

3. Should this Court uphold the jury's punitive damages award where the evidence substantially supports punitive damages against Centennial and the wrongful death statute allows the estate to recover what the individual would have been able to recover had they lived?

4. Did the district court act within its discretion in denying Centennial's request for a new trial and remittitur because Murray's expert witnesses were properly disclosed and the damage award is reasonable given the circumstances of the case?

5. Did Centennial waive its argument that the district court erred in awarding prejudgment interest on future damages?

6. Did the district court properly use the *Beattie* and *Frazier* factors to determine that Murray should be awarded attorney fees and expert witness costs?

Statement of the Case

This is an appeal from a judgment on a jury verdict by the Honorable Jacqueline M. Bluth, District Judge of the Eighth Judicial District Court, Clark County.

When LaQuinta Murray was admitted to Centennial Hospital during a sickle cell crisis, she put all of her trust in Centennial. As the jury found, Centennial intentionally abused that trust when it adopted policies that overrode medical judgment to place profits before patient safety, knowingly created a staffing crisis that inevitably led to errors among the staff, and ignored their own policies regarding reporting critical lab values. The jury awarded a verdict of $16,210,000 in compensatory damages, and $32,420,000 in punitive damages against Centennial.

Now, Centennial argues that the jury's verdict in favor of Murray is subject to the statutory damages cap for professional negligence found in NRS 41A.035, and must be drastically reduced. Despite substantial evidence in trial supporting the jury's punitive damages award, Centennial also argues that there was no basis to award punitive dam-

ages even though the jury was correctly instructed and found Centennial liable for an intentional breach of fiduciary duty. Centennial is attempting to evade the jury's verdict under the veil of a statutory cap that has nothing to do with a claim for breach of fiduciary duty, and under a constitutional argument that ignores the reprehensibility of Centennial's policies and actions.

After post-trial briefing on whether or not the statutory cap should be applied—and if it does apply how it should be apportioned between the fiduciary duty claim and the professional negligence claim—the district court held that the caps in NRS 41A.035 do not apply to Murray's action for breach of fiduciary duty and ordered that the jury's awarded damages in this matter are the final judgment.

Centennial appealed.

STATEMENT OF FACTS

On April 20, 2013, LaQuinta Murray went to the Centennial Hills Hospital Medical Center ("Centennial") because of extreme pain caused by her sickle cell disease. (33 App. 6782.) She was given a dose of Toradol, an anti-inflammatory pain reliever, by an ER doctor, and was admitted to the hospital. (*Id.* at 6782–83.) Her attending physician, Dr.

Arora, ordered 30 mg of Toradol to be administered every 6 hours—for a total of no more than four doses (120 mg) a day, in accordance with a strong FDA warning against overdose. (*Id.*) For administrative and profit-seeking reasons, however, Centennial enacted a medication-administration policy that overrode that medical direction: staff could be spread more thinly by simply allowing most medications, including Toradol, to be given an hour before or after the scheduled dose. So instead of administering Toradol every six hours, staff complying with Centennial policy repeatedly administered doses up to an hour early, leading to multiple days with *five* doses of Toradol (150 mg) for Ms. Murray in a 24-hour period, rather than four. (38 App. 7775–95.) This policy precipitated the very consequences spelled out in the FDA warning: On April 23, Ms. Murray began to have kidney complications, and Dr. Arora discontinued Toradol. (33 App. 6783) By April 24, Ms. Murray was dead. (*Id.* at 6785.)

A. Administration of Toradol

Centennial did not properly administer the medication Toradol. It ignored the FDA approved insert, including the black box warning, which contained dosing instructions and warnings. Centennial allowed

nurses to administer Toradol in a manner that violated these instructions and the warnings.

1. The FDA-Approved Manufacturer's Insert

The FDA mandates that the manufacturer of drugs, such as Toradol, place an insert into the medication packaging setting forth the dosing instructions, warnings, risks and adverse side effects in what is called a "black box warning," which is the most serious warning from the manufacturer. This fact is confirmed by Janine Jones, Director of Nursing for Centennial (12 App. 2235:3–11), Dr. Michael DeBaun, Plaintiffs sickle cell expert (13 App. 2485:8–13, 2537:4–14), Dr. Joshua Schwimmer, Plaintiffs nephrologist expert (15 App. 2924:13–15) and Dr. Arora. (14 App. 2727–28.)

There were three key components to the manufacturer's insert for Toradol in this case, dosing, side effects and the actual black box warning.

First, the dosing instruction states that Toradol may be administered 30 mg every six hours with a maximum daily dose of 120 mg. (25 App. 7206) (emphasis added). The language here is clear: the drug

must not be given more often than every six hours, nor may a daily dose exceed 120 mg.

Second, the manufacturer warns that "adverse reactions increase with higher doses." (*Id.* at App. 7203.) Specifically, the warning states that some of the severe complications include, among others, acute renal (kidney) failure and liver failure. (*Id.*) The warning continues by stating that the side effects can be serious "especially when the drug is used inappropriately." (*Id.*)

Third, every witness who was asked confirmed that the black box warning is the strongest and highest warning issued by the FDA. In the case of Toradol, this highest warning clearly and unequivocally states:

> Increasing the dose of keterolac tromethamine (Toradol) beyond the label recommendations *will not* provide better efficacy but *will increase* the risk of developing serious adverse events.

(*Id.* at App. 7190 (emphasis added).) To be clear, giving Toradol in excess of the instructions and warnings has no benefit to the patient but it will increase the risk of a serious side effect, such as renal failure. Despite these warnings and instructions, Centennial failed to follow the dosage instructions on the FDA mandated insert.

2. Centennial's Administration of Toradol on Ms. Murray

The following chart reflects Centennial's administration of Toradol to Ms. Murray (an asterisk (*) indicates a dose given sooner than six hours)[1]:

Date	Time	Dosage
04/20/2013	1410	30mg
	1849 *	30mg
04/21/2013	Midnight*	30mg
	0521 *	30mg
	1200 Noon	30mg
	1817	30mg
	2352 *	30mg
04/22/2013	0613	30mg
	1218	30mg
	1748 *	30mg
04/23/2013	0014	30mg
	0602 *	30mg
	1222	30mg

Multiple doses were given earlier than every six hours and, consequently, several times more than 120 mg were given in a 24-hour period. For example, from 4/20 at 1410 to 4/21 at 12:00 noon, there were

[1] This chart was used as a demonstrative exhibit during trial. Murray established its veracity through various exhibits (38 App. 7775, 3, App. 7775–95 and 36 App. 7212, 37 App. 7614–51) and through the testimony of the Director of Nursing for Centennial, Janine Jones (12 App. 2218–61). Both parties used the chart; no one questioned its accuracy.

five doses of Toradol at 30 mg each for a total of 150 mg in 21 hours and 50 minutes, violating the black box warning. Even if one excluded this first dose given in the ER, Centennial still administered 150 mg of Toradol in the next 24 hours. Even if one excludes the first two doses and looks at the next 24-hour period, Centennial again administered 150 mg of Toradol within 24 hours.

Murray's experts, Drs. DeBaun and Schwimmer made clear that the timing of the administration of Toradol, reflected in the chart, not only breached the standard of care (13 App. 2542, 2545–46; 15 App. 2928), but also caused acute tubular necrosis, shutting down Ms. Murray's kidneys. (13 App. 2966–67; 15 App. 2930–32.).[2]

B. <u>Staffing Crisis</u>

Along with the overdose of Toradol, Centennial itself acknowledged a staffing crisis. According to its own documents created by

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[2] Centennial says that Dr. DeBaun gave inconsistent testimony on Toradol being "time critical." (*See* Centennial's Opening Brief, at 41). Nonetheless, Dr. DeBaun's testimony is clear that one cannot violate the Black Box Warning and exceed 120 mg of Toradol in a 24-hour period. (13 App. 2541–42, 14 App. 2680, 2697, 2702, 2706.) Centennial does not dispute anywhere in its brief that Murray's nephrology expert testified that giving Toradol sooner than every six hours and exceeding 120 mg in a 24-hour period was a breach of the standard of care.

Nurse Lavin,[3] the clinical supervisor and charge nurse on call on the morning of April 24th, Centennial did not properly staff the floor which was caring for Ms. Murray. (38 App. 7815–19.) This document reports the following problems on the floor during the shift:

> This morning on 4/24/13 I did not have a unit secretary due to low census, the staffing grid does now allow it. I had multiple orders accumulating on the desk throughout the morning. Additionally, I was delegated to watch over a new employee, Aimee Andrada, who was supposed to have still been on orientation but due to a staffing crisis, she was place [sic] to work on the floor independently with only 4 patients instead of the normal 6 (she agreed to this). On the morning of this upgrade, I was: Clinical Supervisor, Unit Secretary, and preceptor to a new RN. I felt that my attention was divided inadequately between each role, I notice that Clint Anderson PA had written orders on this patient Ms. Murray, at about 0900. They included: Rocephin first dose now, Chest Xray today, Blood cultures, sputum culture, urine culture, and some lab work, I did not enter these orders until 11:54AM due to the charts accumulating on the desk, These orders were not carried out timely because they were put in somewhat delayed. The patient went to IMC with a list of orders not carried out (sputum culture, urine culture, blood cultures, lab draws, rocephin IV, etc), Additionally, I was called by pharmacy sometime around 1pm to be informed that the scanner has been broken since 4/23 4pm and the pharmacy did not receive any of my faxes (instead, they needed to be sent via the actual fax machine, not the

[3] Nurse Elise Lavin's last name at the time was Barnes, but had changed to Lavin at the time of trial. For consistency, Murray will refer to her as Nurse Lavin.

> designated pharmacy scanner), No one had informed me that the scanner was broken. This probably prevented the Rocephin first dose now order from being populated on the MAR, however I have not fully investigated this.

(*Id.* at App. 7816–17.) This "staffing crisis" as described by Nurse Lavin was not merely a nursing shortage, but also the failure to have what was identified as a "unit coordinator." Director of Nursing, Janine Jones, testified that a unit coordinator was deemed "ancillary staff' or "support staff." (12 App. 2368.) Per hospital policy, one was not assigned to Mrs. Murray's floor: "the staffing grid does now allow it." (38 App. 7816–17.)

During the trial, Centennial argued that it remedied any "staffing crisis" by having a nurse in training who was to be shadowed take on her own patients that day. (38 App. 7815–19.) Nurse Lavin testified under direct examination from Centennial's counsel that the "staffing crisis" was identified on the prior shift and that it was remedied by having a nurse in training to take on patients independently. (16 App. 3153–55.) Unfortunately, the "fix" for the staffing crisis was to fill the void of a trained qualified nurse with a nurse in training who had no acute care hospital experience and previously worked in a home health

care setting. (16 App. 3118; 12 App. 2372.) This "fix" did nothing with regards to the need for a unit coordinator.

And, despite the testimony that the "staffing crisis" was fixed, the jury heard the following evidence of the staff's inability because of the crisis to care for patients on that floor:

- Nurse Lavin stated that on the morning of this upgrade, I was: Clinical Supervisor, Unit Secretary, and preceptor to a new RN. I felt that my attention was divided inadequately between each role;
- Nurse Lavin stated that Clint Anderson PA had written orders on this patient Ms. Murray, at about 0900. They included: Rocephin first dose now, Chest Xray today, Blood cultures, sputum culture, urine culture, and some lab work, I did not enter these orders until 11:54AM due to the charts accumulating on the desk;

(38 App. 7815–19.)

This was particularly significant because one of Ms. Murray's physician ordered a transfusion of blood (two units) which she never received because of the chaos on the floor due to the staffing crisis. Dr.

Vicuna, a hematologist, ordered a blood transfusion for Ms. Murray at 08:25 a.m. after learning of her lab results. (36 App. 7352.) The order reflects that Dr.Vicuna ordered a blood transfusion of two units to be administered **"NOW"**. (36 App. 7451) (emphasis added). Despite receiving the Order for a blood transfusion **now**, Nurse Craig didn't even enter the Order into the system until approximately one hour later. (*Id.*) (*See also*, 14 App. 2887–88.) Additionally, prior to giving blood, lab work needs to be done; this is called type and match. In this case, Nurse Craig entered the order for type and match as "routine," not stat. (37 App. 7614.)

Testimony from Centennial employees during trial clearly indicated that blood work marked "stat" goes to the front of the line and blood work marked "routine" gets placed at the back of the line. (14 App. 2822.)[4] This is significant because Dr. Schwimmer did a specific

[4] Director of Nursing Janine Jones testified that it was the laboratory techs who put in "routine" on the order to type and match (12 App. 2380–81) but this does not fit with the documented evidence. A review of the document shows that the order was entered by Nurse Craig and contains the word "routine." Later, as one goes towards the top of the page, there are entries made by the lab techs. These entries, however, have nothing to do with whether or not the type and match is done stat or routine. That information was already put into the system by Nurse Craig.

supplemental expert report regarding the failure to provide the blood transfusion as ordered and indeed testified that the failure to give Ms. Murray the transfusion on the morning of April 24, along with the other referenced breaches, caused Ms. Murray's death. (15 App. 2965–66.)

C. The Medication Administration Policy

The nurses at Centennial did not administer the Toradol in the manner reflected in the chart, but not because they made some medical judgment, diagnosis or treatment decision. The nurses ignored Dr. Arora's order on administering Toradol, ignored the FDA approved manufacturer's insert/warnings, and instead administered the Toradol based upon a hospital policy created by Universal Health Services (hereinafter UHS), a non-hospital publicly traded company that is the holding company of Centennial.

Dr. Arora, the physician who ordered the Toradol wrote the order for its administration as 30 mg every six hours. (27 App. 7505; 14 App. 2728.) Dr. Arora testified that he is aware of the FDA approved manufacturer's insert and black box warning on the administration of Toradol and follows the instructions and expects the nurses to know of the instructions and warnings and follow all instructions and warnings.

(*Id.* at 2719, 2727–30.) Dr. Arora further testified that he had no knowledge that the nurses would follow a policy which would stack the doses and exceed the black box warning. (*Id.* at App. 2733.) Dr. Arora testified that he had never seen the UHS medication administration policy, that he would never expect the administration policy to trump the manufacturer's warning, and that he would expect a call from the nurses before they administered a medication in violation of the warning. In this case, there was no call for clarification from the nurses. (*Id.* at 2733–39.)

Without any input from the physician who ordered the administration of Toradol, the nurses ignored the order, ignored the FDA approved manufacturer's insert, ignored the black box warning and instead administered the medication according to a policy created by UHS. (16 App. 3230, 3256.)

The evidence also showed the short shrift that Centennial gave this policy, despite its life-or-death importance. The jury understood this by comparison to three other policies. The front page of the Critical Results Policy reveals that the policy was issued by the director of the hospital, Cynthia Weimer and approved by the medical director, Dr.

June Sigman. (38 App. 7796–97.) The front page of the Laboratory Communication of Critical Results Policy reveals that the policy was issued by director of the hospital Cynthia Weimer and approved by the medical director, Dr. June Sigman. (38 App. 7798.) Finally, the front page of the Critical Test and Critical Results/Interpretations Policy reveals that the policy was issued by the Administration and approved by the CEO/Managing Director, the COO (Chief Operating Officer) and the CNO (Chief Nursing Officer).

In contrast, there was scant evidence that Centennial's medication administration policy underwent any sort of medical review after it was received from UHS. (*See* 16 App. 3230–31, 3256.) Centennial's pharmacy director at the time, Andrew Jackson, nonetheless testified that the policy was internally approved by Centennial. (*Id.* at 3256.) Notwithstanding whether the policy was vetted for patient safety before it was implemented, Jackson testified that Centennial had the authority to designate Toradol as a time-sensitive medication, but chose not to. (*Id.* at 3237.)

UHS referenced the Institute for Safe Medication Practices (ISMP) to give the policy validity. (38 App. 7805.) However, UHS failed

to follow the ISMP guidelines it allegedly relied upon in the creation of its policy. For example, UHS's medication administration policy only lists seven medications out of thousands of medications as being time critical, meaning all but the seven listed can be given an hour early or an hour later than the doctor's order. (16 App. 3221–22.) But the ISMP policy, on which UHS's policy was supposedly modeled, contains multiple examples of time-critical medications that do not appear in UHS's list of seven: for example, ISMP states that opioids, immunosuppressive drugs, flouroquinolones with antacids, and oral hypolglycemics are all time critical; none appear in UHS's list. (16 App. 3251–55.) Ultimately, Pharmacist Jackson concurs that while UHS's policy says it can administer Toradol in the manner in which it did, the manufacturer's insert says the exact opposite.

Ultimately, the jury heard that this policy was not about medical diagnosis, judgment or treatment; it was about efficiency. Pharmacist Jackson testified that it was efficient to "get everybody who has medication that's dosed every 6 hours dosed at the same time" for efficiency purposes. (*Id.* at App. 3236.)[5] Director of Nursing Janine Jones also

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[5] Pharmacist Jackson was not designated as a retained expert, but then

testified that the policy was created by UHS, and that to comply with the 6-hour dosing set forth in the FDA approve manufacturer's insert, the hospital would have to hire more nurses. (12 App. 2337–39, 2340.) When asked why a hospital would create a policy such as the one applicable here, Centennial's nursing expert testified as follows:

> A. Well, it gives you structure in order to give your medications at certain paths so you know what [you're] doing. And you're not willy-nilly just giving medications when you want to.
>
> Q. And if they were to remove some of these requirements, if they were to tighten it up and make it so you didn't have this window, you'd have to hire more nurses to comply, wouldn't you?
>
> A. You'd probably have to have a nurse per patient to comply with the way you'd have to give medications.
>
> Q. Okay, that's a little far fetched, though, wouldn't you agree with me?

---

testified in trial that he was not part of the care and treatment of Ms. Murray and only reviewed the records after the fact. (16 App. 3231). Additionally, Pharmacist Jackson testified at trial that he had prepared a report regarding this incident in 2013, yet that report was never produced. (*Id.*). Plaintiffs moved to exclude the testimony of Pharmacist Jackson because Plaintiffs learned at trial that he was not part of her treating healthcare providers; thus, the rules required an expert report from him which was never produced. (17 App. 3283–88.) Plaintiffs also learned that Pharmacist Jackson had indeed prepared a report which was never produced. (*Id.*)

A. What, having a nurse per patient?

Q. Yes.

A. Yeah, that'll never happen

(17 App. 3333–34.)

Murray's experts, Drs. DeBaun and Dr. Schwimmer, made clear that administering Toradol in the manner in which it was to Ms. Murray, per the administration of medication policy, was inappropriate. For example, when being cross examined by Centennial's counsel, Dr. Schwimmer testified that Toradol should not be eligible for the scheduled dosing times that the policy utilized by Centennial allows. (15 App. 2991) (emphasis added). Furthermore, when asked about giving the medication "plus or minus" one hour, Dr. Schwimmer stated:

> So again, I would say that as I've said before, it's the hospital - I would take it at a higher level. I would say it's the hospital and pharmacy's responsibility to make sure that medications are not given by the nurses even if there's a protocol - or I'm sorry - procedure that violates the black box warning.

(*Id.* at App. 2993.) Dr. Schwimmer continues and states:

> Well, go back to their own policy - the policy for the institution, it should be a medication that you can't give more frequently anymore - more frequently than every 6 hours. That's the way it should be labeled, per the hospital, per the pharmacy. So if the nurses were doing

> something incorrect based upon the policy, it's the hospital and the pharmacy that's responsible for the policy.

(*Id.* at App. 2998.) Dr. Schwimmer explained that the FDA product labeling is very clear and it's a "big deal" to deviate from the warning. They [FDA/Manufacturer] don't want people deviating from the dosing instruction "under any circumstances." (*Id.* at 2926.) Lastly, Dr. Schwimmer stated that the medication administration policy did not comply with the standard of care and that the utilization of the policy by the hospital breached the standard of care. (*Id.* at 2929.)

Dr. DeBaun testified that any time a hospital or medical profession wishes to deviate from the black box warning or use of a drug that can cause complications, a conversation must be had with the patient or his or her family so that they understand the benefits and risks. Any failure to do this constitutes a breach of the standard of care. (13 App. 2619.) Dr. DeBaun added testimony including the following:

> - Anytime a hospital policy contradicts the FDA mandated black box warning, there's a problem with the hospital policy and the system is inadequate. (14 App. 2680–81);
>
> - Any dug that could cause toxicity and could be given outside the clear defined black box warning, in

> my opinion, should be classified as time-critical because otherwise it doesn't draw attention to the healthcare team that you could actually do damage to the patient. (*Id.* at 2697);
>
> - If there was a policy in place that violates the black box warning for a drug that can cause kidney injury, then that policy is flawed. (13 App. 2624).

UHS intentionally created this policy—omitting time-critical medications like Toradol from the list—so that the hospitals it owned could continue a one-to-six nurse-patient ratio. And Centennial accepted that policy as its own, without revision. To require Centennial to comply with the FDA approved manufacturer's insert on dosing instructions, Centennial would have had to hire more nurses. It chose not to.

D. The Fallout from Centennial's Policies

Centennial's medication administration policy and the policy forbidding the assignment of a unit coordinator snowballed with a series of other actions that together killed Ms. Murray.

1. Failure to Strictly Monitor Ms. Murray's Fluids

As described above, the too-frequent administration of Toradol can injure a patient's kidneys. That was one of the reasons that the physician who ordered the use of Toradol (Dr. Arora) also ordered what is

called strict monitoring of all fluids going into the patient (I's) and all fluid coming out of the patient (O's). (14 App. 2730–32.)

Furthermore, Dr. Vicuna ordered to be notified if urinary output dropped below 240ml per 8 hours. (37 App. 7480.) Centennial's Director of Nursing Janine Jones testified that orders must be followed by the nurses and if there are any concerns, then they must be raised with the ordering physician. (12 App. 2205.)

A review of the I's and O's chart in Ms. Murray's records reveal grave problems. (37 App. 7684–85.) The chart shows that there was a serious drop in Ms. Murray's urinary output which was not reported by the nurses of Centennial to the physicians. (13 App. 2558, 2563.) In addition, on their own without an order, the nurses at Centennial decided to no longer record strict output but changed the recording to merely how many times Ms. Murray voided without any regard to whether or not any urine even came out.

Plaintiffs' experts Drs. DeBaun and Schwimmer testified that these actions constituted a breach of the standard of care. (13 App. 2547–2554; 15 App. 2932.)

The manner in which Centennial administered Toradol caused Ms. Murray's kidneys to shut down. The first sign was the drop of urine output which Centennial staff failed to report to Ms. Murray's physicians. The next sign of kidney failure would be evident in Ms. Murray's laboratory values.

2. The Failure to Report Critical Lab Values

As a person's kidneys fail, laboratory values reflect the kidneys shutting down. In Ms. Murray's case, it was the dramatic increase in her potassium levels in her blood.

In the early morning hours of April 24, 2013, Centennial staff drew blood from Ms. Murray at approximately 2:42 a.m., with the result showing that Ms. Murray's potassium level was critically high at 6.8. (37 App. 7691.) The evidence shows that the lab employee performed a "called to and read back" at 6:10:59 a.m.; the lab employee called Jennifer Estopare (Ms. Murray's nurse at that time) and read the value to the Centennial Nurse Estopare, and had Nurse Estopare confirm that she knew of the critical lab value. (*Id.*) (*See also* 14 App. 2823.)

According to Centennial policy:

> If the licensed nurse received the Critical Test or Value/Interpretation, he/she shall *immediately* contact

> the patient's ordering or covering physician to convey the Critical Test or Value/Interpretation, and obtain orders as appropriate.

(*Id.* at App. 7812.) Centennial's Director of Nursing, Janine Jones, also confirmed that a 6.8 potassium value was a critical value requiring immediate attention which is what is required under the Centennial policy referenced above. (12 App. 2286–88.)

Despite learning of the critical lab value at 6:10 a.m., Jennifer Estopare did not call Dr. Arora until 8:00 a.m., 1 hour and 50 minutes after receiving a critical lab value. (36 App. 7347.)

Plaintiffs' expert, Dr. Schwimmer testified that the potassium level was critical and that the nurse breached the standard of care by not communicating that information immediately to the doctor. (15 App. 2934–36, 2952.)

By then, Ms. Murray was in critical condition and needed urgent attention, but she did not get the urgent care she needed.

E. Disclosure of the Medication Administration Policy

Centennial argues that it was unfairly surprised by the testimony of Murray's experts regarding the medication administration policy.

A review of Centennial's Initial Disclosure of February 4, 2015

does not reveal any policies and/or procedures in the case nor does it reveal any report made by Pharmacist Jackson and/or incident reports regarding Ms. Murray. (*See* 9 App. 1637–43.) Centennial's defense revolved around its medication administration policy, but it was not produced at the Initial Disclosures. Centennial made its First Supplemental Disclosure, Second Supplemental Disclosure and Third Supplemental Disclosure and there was no incident report produced, no other report (such as Pharmacist Jackson's report) produced by Centennial, and no policy and/or procedures produced.

With a trial date set for March 2016, Plaintiffs filed a Motion to Amend the Complaint on Order Shortening Time, on December 28, 2015, to add a claim for breach of fiduciary duty for the "staffing crisis" identified in the newly produced incident report. (*See* 9 App. 1626–35.) Plaintiffs could not have included in their motion to amend issues regarding the medication administration policy as it still had not been produced.

On January 12, 2016, the district court heard oral argument on Plaintiffs' motion to amend and include a claim for breach of fiduciary duty based upon the information contained in the incident report. The

motion was granted that same day. (*See* 9 App. 1748–50.) It was not until the day after the hearing on the motion to amend, after Murray's experts had submitted their reports and been deposed did Centennial finally produce the UHS Medication Administration Policy. (*See* 9 App. 1654–73.)

Plaintiffs experts Drs. DeBaun and Schwimmer could not specifically use the phrase "medication administration policy" in their reports or depositions because Centennial had not produced this policy. Nonetheless, each of these experts placed information in their report to put Centennial on notice that both of them would be critical of UHS's medication administration policy.

All throughout Drs. DeBaun and Schwimmer's expert reports and supplemental/rebuttal reports, there are repeated references that the manner in which the Toradol was administered was inappropriate, a violation of standards and a violation of the FDA's black box warning.

Lastly, it was Centennial's own counsel that specifically brought up the hospital's medication of administration policy with Plaintiffs' expert Dr. DeBaun:

> Q. All right. Well, let me ask you this, Doctor. Well since you – well, strike that.

> If I were to tell you that per the Medication Administration Policy that was not given to you, our – my nurses gave this medication each of those times within the time prescribed for that policy, you have no reason to disagree with that; right?
>
> A. No, I have no reason. Except that I would say that if you have a policy – if a nursing – I mean, people make mistakes. But if there is a policy that violates the black box warning for a drug that can kidney injury, then that policy is flawed.

(13 App. 2622–24.)

F. <u>Procedural History</u>

On April 24, 2014, Murray filed a wrongful death action alleging medical negligence, vicarious liability, and negligent hiring, training, and supervision. (1 App. 2.) On January 12, 2016, Murray filed an amended complaint adding a breach of fiduciary duty claim. (*Id.* at 227.) District Court Judge Bare allowed Murray to add the claim. (33 App. 6786.) Later, then-Judge Cadish heard arguments on Centennial's motion for partial summary judgment on the claim of breach of fiduciary duty and found that Murray could present the claim to the jury. (*Id.*)

At trial, the jury awarded Murray $16,210,000 in compensatory damages, and $32,420,000 in punitive damages. (19 App. 3709.) The

jury found both that Centennial employees had breached the standard of care that proximately caused Ms. Murray's death (*id.* at 3706–07), and that Centennial employees "intentionally breach[ed] their fiduciary duty owed to LaQuinta Murray." (19 App. 3709.) The jury had been instructed to find such a breach only if "the agents of Centennial Hills Hospital intentionally exploited LaQuinta Murray for its own gain or benefit." (*Id.* at 3688.) Having found such a breach, the jury also found that "employees of Centennial Hills Hospital engaged in conduct with fraud, oppression, or malice toward LaQuinta Murray" (19 App. 3710) and on that basis elected to award punitive damages (19 App. 3711).

After the district court entered judgment for the full amount assessed by the jury, Centennial filed motions pursuant to NRCP 50 and 59. (21 App. 4113–16.) Initially, the district court granted in part Centennial's motion for judgment as a matter of law on the fiduciary duty claim and applied the statutory caps in NRS 41.035 to reduce Murray's damages to $1,339,000 in compensatory damages and $4,017,000 in punitive damages. (30 App. 6217–36.) Murray filed a Rule 59 motion seeking a reversal of the previous order and reinstatement of the full jury award. (31 App. 6384–99.)

In a detailed, 25-page order crafted by the district court itself, the district court granted Murray's motion and reinstated the fiduciary duty claim. (33 App. 6781.) The court reviewed the trial transcripts and procedural history and then analyzed the law governing fiduciary-duty claims in this circumstance. The district court stated that although the Supreme Court has not addressed the issue of whether a hospital owes a fiduciary duty to its patients, applying the same rationale that the Court has previously used, "this [district court] sees support for the argument that a hospital could owe a fiduciary duty to its patients under certain facts and circumstances." (33 App. 6788.)

According to the district court, this fiduciary duty had strict limitations and would apply only if "evidence was presented to the jury that illustrated [Centennial] intentionally understaffed the hospital and/or created a medication-administration policy due to the hospital's business goals, desires, and/or profit." (33 App. 6794.)

Applying this standard, the district court found that because Murray did not proffer expert testimony showing that the staffing numbers were inappropriate on Ms. Murray's floor that day and there was no evidence presented that Centennial intentionally understaffed the floor

with the intent to cut costs or gain financial advantage, Plaintiffs failed to prove a breach of fiduciary duty because of understaffing. (*Id.* at 6795–96.)

The district court also found, however, that the jury could have reasonably found Centennial breached its fiduciary duty owed to Ms. Murray because of the medication administration policy. (*Id.* at 6803.) "The jury heard ample evidence in regards to the medication administration policy that allowed nurses to administer Toradol in excess of the 'black box warning,'" including expert testimony, that Centennial did not draft the policy, and that administering Toradol according to the black box warning would have required Centennial to lower the nurse to patient ratio, thereby requiring them to hire more nurses. (*Id.* at 6803–04.)

SUMMARY OF THE ARGUMENT

Centennial's misguided argument rests on the premise that a hospital cannot owe a fiduciary duty to its patients, and even if it does, such a claim will always be "inextricably intertwined" to a professional negligence claim, and therefore subject to the statutory caps in chapter 41A. This argument ignores the reality that Murray's intentional tort

claim for breach of fiduciary duty rests on the premise that Centennial acted intentionally in enacting the medication administration policy, and that it did so because of a profit motive to keep costs low rather than as an exercise of medical judgment. The policy fails to consider FDA black box warnings and overrides the instructions of doctors when the lives of patients are on the line. The district court has already found that it was reasonable for the jury to make this conclusion based on the substantial evidence presented by Murray at trial. (33 App. 6803.)

Nevada voters enacted KODIN to reform medical malpractice awards in an effort to provide greater predictability to health care professionals. Nevada voters did not enact a statutory scheme that allows institutions to avoid jury awards on intentional torts simply because the claim stems from the same initial event as a medical malpractice claim. Centennial should not be allowed to avoid a jury's award and the district court's confirmation of that award by arguing that every claim against a hospital that stems from a patient's death will fall under KODIN. This Court should affirm the jury's verdict and the district court's confirmation of that verdict.

ARGUMENT[6]

I.

CENTENNIAL BREACHED ITS FIDUCIARY DUTIES

The district court correctly entered judgment against Centennial for intentional breach of fiduciary duty. Ms. Murray entrusted Centennial with her life when she surrendered her care to Centennial in a time of extreme pain and distress. As the jury found, Centennial intentionally abused that trust. Centennial adopted policies without considering patient safety, knowingly created a staffing crisis that predictably led to errors among the hospital staff, and ignored their own policy for reporting critical lab values.

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[6] **Standard of review:** "A jury's verdict supported by substantial evidence will not be overturned unless the verdict is clearly erroneous when viewed in light of all the evidence presented." *Frances v. Plaza Pac. Equities, Inc.*, 109 Nev. 91, 94, 847 P.2d 722, 724 (1993). Motions under NRCP 50(a) and 50(b) are reviewed *de novo*. *Motor Coach Indus., Inc. v. Khiabani ex rel. Rigaud*, 137 Nev., Adv. Op. 42, 493 P.3d 1007, 1011 (2021). "A court may not substitute its own judgment in place of the jury's judgment unless the jury erred as a matter of law." *Frost v. Tab Contractors, Inc.*, 126 Nev. 711, 367 P.3d 770 (2010). And "[a]lthough not separately appealable as a special order after judgment, an order denying an NRCP 59(e) motion is reviewable for abuse of discretion on appeal from the underlying judgment." *AA Primo Builders, LLC v. Washington*, 126 Nev. 578, 589, 245 P.3d 1190, 1197 (2010).

A. Hospitals Are the Fiduciaries of their Patients

1. Courts Recognize the Fiduciary Duties of Hospitals Based on Their Power and the Trust Reposed in them

As the nature of health care has changed over the last century and into this one, courts and commentators have begun to recognize the fiduciary nature of the relationship between patients and the hospitals to whom those patients entrust their lives. *See generally* Barry R. Furrow, *Patient Safety and the Fiduciary Hospital: Sharpening Judicial Remedies*, 1 DREXEL L. REV. 439 (2009); Robert Gatter, *The Mysterious Survival of the Policy Against Informed Consent Liability for Hospitals*, 81 NOTRE DAME L. REV. 1203, 1268–70 (2006) ("As hospitals have taken on responsibilities to organize the delivery of health care to their patients, they enter into fiduciary relationships with each of their patients as well.").

These duties are not uniform. They reflect the many ways in which a patient surrenders the course of treatment, especially in emergency situations, and places that trust in the hospital based on its superior skill and power. They include duties of disclosure. *Wohlgemuth v. Meyer*, 139 Cal. App. 2d 326, 331, 293 P.2d 816, 820 (1956) (recognizing

hospital's fiduciary duty to disclose a patient's cause of death to the patient's spouse). They include duties of confidentiality. *Herman v. Kratche*, 2006-Ohio-5938, ¶¶ 18–20 (citing *Strock v. Pressnell*, 527 N.E.2d 1235 (Ohio 1988) and *Stamper v. Parr–Ruckman Home Town Motor Sales*, 265 N.E.2d 785 (Ohio 1971)). And critically, "nonprofit hospitals owe a fiduciary duty to the public with regard to staffing decisions." *DiCarlo v. St. Mary Hosp.*, 530 F.3d 255, 268 (3d Cir. 2008) (citing *Greisman v. Newcomb Hosp.*, 192 A.2d 817 (N.J. 1963) and *Doe v. Bridgeton Hosp.*, 366 A.2d 641 (N.J. 1976)).

2. The Hospital has a Duty to Establish and Follow Policies for the Health and Safety of Patients

Other courts, without invoking the word "fiduciary," impose similar duties on hospitals based on their position of trust and superior knowledge. As "the sick leave their homes and enter hospitals because of the superior treatment there promised them," a patient "should be able to expect that the hospital will follow its rules established for his care." *Williams v. St. Claire Med. Ctr.*, 657 S.W.2d 590, 594–95 (Ky. Ct. App. 1983) (quoting *Univ. of Louisville v. Hammock*, 106 S.W. 219, 220 (Ky. 1907)), *discussed in* Furrow, *supra*, at 460–61. Conversely, the hospital must not "institute policies or practices which interfere with

the doctor's medical judgment." *Muse v. Charter Hosp. of Winston-Salem, Inc.*, 452 S.E.2d 589, 594 (N.C. Ct. App. 1995), *aff'd*, 464 S.E.2d 44 (1995), *discussed in* Furrow, *supra*, at 462–63. In *Muse*, for example, the hospital's policy of discharging patients once their insurance expired forced a doctor to stop treating a suicidal patient, who soon after his discharge killed himself. *Id.* Although the court did not couch the hospital's duty in the language of fiduciaries, the obligation to protect the patient even if that means absorbing unfunded costs in some exceptional circumstances amounts to a "species of fiduciary duty." Furrow, *supra*, at 463.

Dangerous or nonexistent policies commonly underlie these types of claims. In *Jennison v. Providence St. Vincent Medical Center*, the Oregon Court of Appeals upheld a judgment against a hospital that "had no policy or procedure regarding the followup on central lines" placed during operation or intensive care, leaving a call from radiology to "potentially go to one of five different people" and with no procedure for alerting others whether that call was actually made. 25 P.3d 358, 363 (Or. Ct. App. 2001), *discussed in* Furrow, *supra*, at 468–69. And in *Hook v. Auriemma*, the court held that a hospital's failure to transfer a

patient to the intensive care unit when the patient requires monitoring of low blood pressure can breach the nondelegable duty "to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients." 74 Pa. D. & C.4th 186, 192–93 (Pa. Ct. Com. Pl. 2005) (quoting *Thompson v. Nason Hosp.*, 591 A.2d 703, 707 (Pa. 1991)), *discussed in* Furrow, *supra*, at 467–68.

3. The Hospital's Independent Fiduciary Liability is not the Same as Medical Malpractice

These duties are clearly differentiated from traditional notions of medical malpractice: "It requires not medical expertise, but administrative expertise, to enforce rules and regulations which were adopted by the hospital to insure a smoothly run hospital routine and adequate patient care and under which the physicians here agreed to operate." *Johnson v. St. Bernard Hosp.*, 399 N.E.2d 198, 205 (Ill. App. Ct. 1979). In *Johnson*, the court reversed summary judgment for a hospital that had failed to ensure that a doctor's request for a nonemergency consultation was fulfilled within 48 hours: the unobserved policy was "evidence of the responsibility which the hospital assumed for the care of the patient." *Id.* Courts have repeatedly made clear that "[t]he duty to uphold the proper standard of care runs directly from the hospital to the

patient . . . . Therefore, an injured party need not rely on the negligence of a third-party, such as a doctor or nurse, to establish a cause of action for corporate negligence." *Rauch v. Mike-Mayer*, 783 A.2d 815, 827 (Pa. Super. Ct. 2001) (internal citations omitted), *discussed in* Furrow, *supra*, at 445–46. In *Rauch*, an elderly woman underwent a risky elbow surgery and died; though the operation itself was flawless, the very decision to operate resulted from the hospital's inadequate attention to the patient's best interests. *Id.* Because the claim "arises from the policies, actions or inaction of the institution itself," the hospital "is held directly liable, as opposed to being vicariously liable, for its own negligent acts." *Id.*

"The recognition of institutional responsibility to better handle informed consent, disclosure of data, and revelation of errors turns the hospital finally into a recognizable legal fiduciary with an obligation to protect its patients from harm from third parties." Furrow, *supra*, at 483.

B. Nevada Should Recognize these Fiduciary Duties

These duties exist in Nevada, too. The hospital's duties to "oversee all persons who practice medicine within its walls as to patient care"

and "to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients" are but an outgrowth of the duty "to select and retain only competent physicians." *Thompson v. Nason Hosp.*, 591 A.2d 703, 707–08 (Pa. 1991) (citing *Johnson v. Misericordia Cmty. Hosp.*, 301 N.W.2d 156 (Wis. 1981)), *discussed in* Furrow, *supra*, at 466. This foundational negligent-credentialing claim is widely recognized. *See Larson v. Wasemiller*, 738 N.W.2d 300, 310 (Minn. 2007); *Browning v. Burt*, 613 N.E.2d 993, 1007 (Ohio 1993); *Greenwood v. Wierdsma*, 741 P.2d 1079, 1088 (Wyo. 1987); *Johnson v. Misericordia Cmty. Hosp.*, 301 N.W.2d 156 (Wis. 1981). In fact, claims against health-maintenance and managed-care organizations in the wake of the hepatitis C outbreak in Clark County last decade were premised on the organization's "duty to establish and implement a quality assurance program to oversee the medical providers within its network"—a duty that district judges across the Eighth Judicial District recognized (including then-Judge Cadish, *see Lynam v. Health Plan of Nev. et al.*, Case No. A583772), and that this Court never dispelled. *See Sadler v. PacifiCare of Nev.*, 130 Nev. 990, 992–93, 340 P.3d 1264, 1266 (2014) (reversing dismissal of claims based on this duty).

C. Murray Properly Pleaded a Claim <u>for Breach of Fiduciary Duty</u>

Murray was not required to state every such breach with particularity. *See* NRCP 8(a) *Chavez v. Robberson Steel Co.*, 94 Nev. 597, 599, 584 P.2d 159, 160 (1978) ("Nevada is a notice-pleading jurisdiction and liberally construes pleadings to place into issue matter which is fairly noticed to the adverse party . . . . A single count may allege alternative theories of recovery."). Murray put Centennial on notice of both its breach of fiduciary duties claims—intentional understaffing and the medication administration policy. Its amended complaint properly pleaded:

> 76. As a hospital providing care and treatment to LAQUITA, Defendant CENTENNIAL owed a fiduciary duty to LAQUINTA and was obligation to exercise the utmost good faith in caring for and treating her. Defendant held a superior authoritative position in the professional relationship with LAQUINTA and LAQUINTA placed her confidence and trust in Defendant CENTENNIAL to care and treat her with competence, diligence and utmost good faith.
>
> 77. Plaintiff relied upon Defendant CENTENNIAL to make appropriate and good faith decisions regarding her medical care and treatment, including but not limited to ensuring that sufficient staff was available to provide such care and treatment.
>
> 78. LAQUINTA placed her trust and confidence in Defendant CENTENNIAL to care for and treat her

> without allowing its fiduciary duty regarding patient care to be improperly influenced by any other factors, including but not limited to Defendant's business goals, desires, and/or profit.
>
> …

(33 App. 6792.) Judge Bare, then-Judge Cadish, and Judge Bluth all found that Murray properly pleaded a claim for breach of fiduciary notice that put Centennial on notice. (*Id.*) The amended complaint alleges that Centennial owed a duty for breach of fiduciary duty, that Ms. Murray relied on Centennial because of their superior position and skill, and that Centennial's action were influenced by improper motives such as profit. (*Id.*) While the district court found that the hospital understaffing claim did not have enough supporting evidence, it also found that the claim based on the medication administration policy did have enough evidence to support the jury's verdict. (*Id.*) None of the judges found that Murray had not properly put Centennial on notice of its fiduciary duty claim.

Further, some of Centennial's breaches, such as the adoption of a medication administration policy that allowed dangerously premature dosing of medications such as Toradol, were not disclosed until later in litigation, after expert disclosures and depositions. Nevertheless, even

without the disclosure of the medication administration policy, Murray's experts still put Centennial on notice in their expert reports that they would testify that the administration of Toradol at the rate that it was given was inappropriate and a breach of the standard of care.

II.

CHAPTER 41A IS INAPPLICABLE TO BREACH OF FIDUCIARY DUTIES

Murray's fiduciary duty claim is separate from his claim for professional negligence. Thus, despite Centennial's contention that the claims are inextricably intertwined, the breach of fiduciary duty claim was for the hospital's deadly policy, not for any medical judgment, diagnosis, or treatment.

A. KODIN is Meant to Protect Doctors who Try to Follow the Rules, not Institutions with Bad Policies

Centennial, the American Medical Association, and Your Nevada Doctors argue that KODIN was designed to prohibit awards that are just the type that the jury awarded here. This argument puts words into the mouths of voters; the statute mentions nothing beyond professional negligence. The voters approved legislation to create a hard cap limiting noneconomic damages from an incident of malpractice. KODIN

does not control claims for breach of fiduciary duties against institutions when their policy leads needless death.

If KODIN was interpreted to apply the statutory cap in cases like Ms. Murray's, the result would be absurd. The benefits of the cap would disproportionately go to those who had acted the most reprehensibly—those that should have punitive damages levied against them to deter future wrongdoing. The statutory cap makes sense when doctors who do their best to provide quality care for their patients make a mistake and need a safety net; the cap prevents these doctors from facing insurmountable damage judgments. This is the spirit embodied in the KODIN initiative that is designed to "provide greater predictability and reduce costs for health-care insurers and, consequently, providers and patients." *Tam v. Eighth Jud. Dist. Ct.*, 358 P.3d 234, 239 (Nev. 2015).

The statutory cap does not make sense if it protects institutions that create bad policy and have no incentive to eliminate such policies because they will never face a large enough award—one that actually reflects the victims' true damages—to make a difference. This Court should not interpret KODIN to protect the worst actors from taking responsibility for their actions.

B. Because Murray's Fiduciary Duty Claim is Separate from the Professional Negligence Claim, Chapter 41A does not Apply

A damages cap that may apply to one claim does not infect and reduce the value of all other claims that have been separately pleaded and proved. The damages cap applies when it applies, but it does not apply when it does not. If it were otherwise, all kinds of damages caps would taint uncapped causes of action, which would be contrary to legislative intent. As an example, the damages cap on claims against political subdivisions of the state, NRS 41.035, would impermissibly eliminate uncapped claims for violations of federal law, such as 42 U.S.C. § 1983.

Here, an action "based upon professional negligence" caps damages at $350,000, but a separate claim that is not "based upon professional negligence" is not capped.

1. By its Text, NRS 41A.015 is Limited to Acts that are Merely Negligent

The then-applicable statute defined professional negligence as a "*negligent* act or omission" in the provision of health care, not an *intentional* breach of a fiduciary duty. NRS 41A.015 (emphasis added). Medical malpractice, as it was then called, was listed separately from

"conduct that violates the trust of a patient and exploits the relationship between the physician and the patient" as grounds for physician discipline. NRS 630.301(4), (7). And other provisions of NRS chapter 41A repeatedly make clear that a presumption of "negligence" to which the provisions of the chapter apply arises from evidence of unintentional or unintended harm—a "foreign substance . . . *unintentionally* left within the body of a patient following surgery" or an "*unintended* burn caused by heat, radiation or chemicals was suffered in the course of medical care"—not intentional torts. *See* NRS 41A.100(1)(a), (c) (emphasis added).

The Legislature knew how to draft a damages cap that would encompass all kinds of torts and degrees of culpability, as it did precisely that in enacting the cap for claims against political subdivisions, which limits "damages in an action *sounding in tort*." NRS 41.035(1) (emphasis added). Note, too, that NRS 41.035(1) applies to *any* "act or omission," as contrasted with NRS 41.015's application to a "*negligent* act or omission."

As a statute in derogation of the common law, NRS 41A.015 is strictly construed. *Shadow Wood HOA v. N.Y. Cmty. Bancorp.*, 132

Nev. 49, 59, 366 P.3d 1105, 1112 (2016). Centennial provides no compelling reason to depart from the common understanding of the word "negligence," as the inadvertent failure to use reasonable care, to have it include willful and intentional wrongs, which are different in kind. *See Hart v. Kline*, 61 Nev. 96, 116 P.2d 672, 673–74 (1941) (distinguishing among ordinary negligence, gross negligence, and willful and intentional wrongs); *Cornella v. Churchill Cty. Justice Court*, 132 Nev. 587, 594, 377 P.3d 97, 102–03 (2016) (adopting similar definition of negligence and noting that "[w]hen the Legislature does not specifically define a term, this court "presume[s] that the Legislature intended to use words in their usual and natural meaning." (quoting *Wyman v. State*, 125 Nev. 592, 607, 217 P.3d 572, 583 (2009))).

NRS chapter 41A is simply not interested in conduct other than negligence; for other torts, the existing background of statutory and common law remains intact.

2. Unlike NRS 41A.015, NRS 41.141 Addresses Intentional Torts

Looking at the broader statutory context also shows how negligence, even professional negligence, differs in critical ways from inten-

tional torts. The best evidence that the award on Murray's claim for intentional breach of fiduciary duty is not limited by the cap in NRS 41A.035 is Nevada's comparative-fault statute, NRS 41.141.

The common law had two harsh doctrines: tortfeasors of all kinds were jointly liable for any judgment for a fault-free plaintiff, regardless of each defendant's respective culpability; and a partially negligent plaintiff would recover nothing against a merely negligent defendant. *See Café Moda v. Palma*, 128 Nev. 78, 80, 272 P.3d 137, 139 (2012) (citing *Warmbrodt v. Blanchard*, 100 Nev. 703, 707–08, 692 P.2d 1282, 1285–86 (1984)).

NRS 41.141 abrogates both doctrines, but only when (1) the plaintiff's comparative negligence is a bona fide issue, *Buck ex rel. Buck v. Greyhound Lines, Inc.*, 105 Nev. 756, 764, 783 P.2d 437, 442 (1989), and (2) the defendant's conduct does not fall within one of five statutory exceptions. NRS 41.141(1), (5); *see Café Moda*, 128 Nev. at 80, 272 P.3d at 139 (citing *Warmbrodt*, 100 Nev. at 707–08, 692 P.2d at 1285–86). Because intentional torts are excepted, an intentional tortfeasor remains jointly liable under the common law for the entire judgment. NRS 41.141(5)(b); *see Café Moda*, 128 Nev. at 84, 272 P.3d at 141.

Critically, NRS 41A.045, the several-liability statute in medical-malpractice cases, does not overturn that determination. Both statutes allow apportionment only of a party's *negligence*. Indeed, NRS 41.141(5) is the more specific statute on this question, for in retaining joint liability for certain acts, the Legislature expressly provided that "concerted acts" would not include "*negligent* acts committed by providers of health care while working together to provide treatment to a patient." NRS 41.141(6)(a) (emphasis added). Conspicuously absent is any suggestion that joint liability is eliminated for "*intentional torts* committed by providers of health care." That the Legislature so carefully narrowed the "concerted acts" exception while leaving the "intentional tort" exception untouched confirms that NRS chapter 41A does not supersede intentional-tort claims.

3. The Holdings in* Szymborski *and* Curtis *do not Conflict with the Proposition that Chapter 41A does not Apply to a Breach of Fiduciary Duty

Both of these cases stand for the proposition that courts should look to the "substantial point or essence of each claim rather than its form to see whether each individual claim is for medical malpractice or ordinary negligence." *Szymborski v. Spring Mtn. Treatment Ctr.*, 133

Nev. 638, 641, 403 P.3d 1280, 1285 (2017); *see also Estate of Curtis v. S. Las Vegas Med. Invs., LLC*, 136 Nev. 350, 353, 466 P.3d 1263, 1266 (2020). Looking to the essence of each claim in this case shows that the claims are distinguishable.

In *Szymborski*, the only claims alleged by plaintiff were negligence claims. 133 Nev. at 641, 403 P.3d at 1282. Of the claims that did survive because they were not for medical malpractice (negligence, social-worker negligence, gross negligence, negligence per se, and negligent hiring, supervision, and training), each was necessarily related to the professional negligence claim because each claim had to originate from the same event: the treatment center discharging the patient with no regard for its discharge planning obligations. *Id.* at 640, 1283. Still, these claims were of the nature that the jury could understand the reasonableness of the health care provider's actions without expert testimony, and the facts underlying the claim did not "involve medical diagnosis, treatment, or judgment." *Id.* at 648, 1288. Thus, the Court deemed the claims ordinary negligence rather than medical malpractice.

And in *Curtis*, the Court created a two-part test to distinguish between negligence and professional negligence: "(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." 136 Nev. at 356, 466 P.3d at 1268. Ultimately, the claim that the nurse had inadvertently administered morphine to the wrong patient was deemed ordinary negligence, and the claim that the facility had failed to properly monitor and care for the patient was professional negligence. *Id.*

Murray's claim of an intentional breach of fiduciary duty is different from the distinctions in the types of negligence in *Szymborski* and *Curtis*. An intentional tort cannot, by its definition, be professional *negligence*. But even if *Szymborski* and *Curtis* do apply, Murray has shown that his breach of fiduciary duty claim over the medication administration policy does not involve "medical diagnosis, treatment, or judgment." The fiduciary duty claim does not involve the evaluation of a medical decision; it is rooted in a cost-cutting administrative policy that has a non-physician overriding the medical decisions of doctors and nurses.

Murray's contention is not that the nurses failed to follow the policy, but that the policy itself is a breach of fiduciary duty. Further, jurors can intuitively understand a failure of policy and the financial motives for its adoption. Even assuming expert testimony were necessary to explain the effects and dangers of Toradol, they do not need an expert to understand the reprehensibility of a policy that, without informing the patients in Centennial's care, for the sake of financial convenience invites staff to ignore doctors' orders and FDA black-box warnings. As the jurors here understood, this was not a medical judgment in the way that a question of which drug to prescribe an individual patient in particular circumstances might be. Rather, this was a blanket policy that controls the administration of all medications, that was not created by medical or pharmaceutical staff, and that predictably causes nurses to disregard the medical judgment of doctors and the FDA in treating individual patients with time-critical medications.

Because Murray's breach of fiduciary duty claim is based on a policy decision, not a medical decision, the fiduciary duty claim is not inextricably linked to the professional negligence claim.

4. Centennial Cites Inapt Authority to Argue Murray's Fiduciary Claim is one of Professional Negligence

Centennial cites irrelevant authority for its argument that the district court improperly exempted Murray's fiduciary duty claim. Despite citing *Humboldt General Hospital v. Sixth Judicial District Court* for the proposition that allegations of intentional conduct do not exempt a claim from chapter 41A, the Court's decision in *Humboldt* actually supports Murray's position, not Centennial's. 132 Nev., Adv. Op. 53, 376 P.3d 167 (2016). There, the Court recognized that when a patient consents to treatment, but there is a question about the scope of consent—i.e., whether it was "*informed* consent"—such a claim raises a claim of negligence, not battery or assault. 132 Nev. Adv. Op. 53, 376 P.3d 167, 171 (2016) (quoting *Mole v. Jutton*, 846 A.2d 1035, 1042 (Md. 2004)). But "where a plaintiff claims not to have consented at all to the treatment or procedure performed by a physician or hospital," the allegation "constitutes a battery claim"—a true intentional tort—and so is not subject to the restrictions of NRS chapter 41A. *Id.*

And while Centennial is technically correct that characterizing a claim as intentional does not change its underlying nature, *see*

Schwarts v. University Medical Center of Southern Nevada, 2020 WL 1531401, at *1–2 (Nev. Mar. 26, 2020), none of the authority it cites suggests that Murray's fiduciary duty claim is in name only. In *Stutts v. County of Lyon*, the court dismissed both the negligence claim and the intentional tort claim, but it only classified the negligence claim as malpractice. 319CV00552MMDCLB, 2020 WL 1904581, at *5 (D. Nev. Apr. 17, 2020). The intentional tort case was dismissed for failure to respond. *Id.* ("Plaintiff fails to address any of these arguments in his response. Therefore, the Court dismisses Plaintiff's assault, battery, sexual assault, IIED and NEID claims against Mayer and Elmquist.").

In *Shorter v. City of Las Vegas*, the court only dismissed the state negligence claim; it did not dismiss the federal claim of deliberate indifference, the intentional tort. 216CV00971KJDCWH, 2019 WL 266285, at *1 (D. Nev. Jan. 17, 2019) ("As to Shorter's § 1983 claim against Correct Care, the Court denied summary judgment finding a genuine issue of material fact whether Correct Care failed to implement policies or procedures to prevent deliberate indifference to her medical needs or in the alternative failed to follow those policies."). And finally, in *O'Neal v. Las Vegas Metro Police Department*, the court confirmed that there is a

distinction between negligence and the intentional tort of deliberate indifference. 2018 WL 4088002, at *3 (D. Nev. Aug. 27, 2018) ("A § 1983 deliberate indifference claim is not a medical malpractice claim, so no affidavit is required under § 41A.071.").

The same is true for Centennial's authority that deals with the irrelevant question of whether there is some independent need for the separate cause of action. In *Neade v. Portes*, the Illinois court said that "the injuries suffered by plaintiff as a result of Dr. Portes' medical care are sufficiently addressed by application of traditional concepts of negligence." 739 N.E.2d 496, 505–06 (Ill. 2000). At the time, Illinois did not have a cap on noneconomic damages. Illinois later enacted such a cap, *see* Pub. Act 94-677, § 330 (enacting 735 Ill. Comp. Stat. 5/2-1706.5, effective Aug. 25, 2005), but it was declared unconstitutional in 2010.

Similarly, *Pegram v. Herdrich*, addressed the unique federal duties created by ERISA, 29 U.S.C. § 1001 *et seq*. 530 U.S. 211 (2000). Although the statute creates "fiduciary duties," the Court carefully differentiated claims arising under that federal statutory scheme from those arising under state common law. *Id.* at 235–36. The Court recognized that ERISA's unique scheme allowed the ERISA trustee to "wear

different hats," including taking actions adverse to the financial and other interests of plan beneficiaries. *Id.* at 225. The Court drew this contrast between state-law notions of fiduciary duties and those imposed by ERISA to make clear the limited scope of ERISA's reach, which is entirely distinguishable from the case here.

C. The Cap on Noneconomic Damages Does Not Apply to Punitive Damages

Murray was awarded punitive damages for his claim of intentional breach of Centennial's fiduciary duties, a claim wholly outside of the limits placed on professional negligence claims by chapter 41A.

Further, even if chapter 41A did apply, the statutory cap would not apply to Murray's punitive damages award because punitive damages are not noneconomic damages. Punitive damages are neither economic nor noneconomic damages, as they are not awarded to compensate any loss. Instead, they are awarded to punish and deter a defendant's conduct. *Bongiovi v. Sullivan*, 122 Nev. 556, 580, 138 P.3d 433, 450 (2006) ("Punitive damages are designed not to compensate the plaintiff for harm suffered, but, instead, to punish and deter the defendant's culpable conduct."). NRS 41A.035 specifically states that the

plaintiff can recover noneconomic damages, "but the amount of noneconomic damages awarded in such an action must not exceed $350,000." Because punitive damages are not nonecomomic damages, the plain language of the statute shows that they are not subject to the statutory cap.

Additionally, Centennial argues that punitive damages should be classified as "non-pecuniary damages" and thus included as noneconomic damages in NRS 41A.011. However, both pecuniary and non-pecuniary damages are compensatory damages because they are damages that occur as a direct result of the injury. *See* NRS 41A.011 (noneconomic damages are expressly defined as "damages to *compensate* for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damages") (emphasis added). Punitive damages are not classified as compensatory damages because they are intended to punish and discourage certain behavior, not compensate a plaintiff as a direct result of an injury. Thus, because punitive damages are not compensatory damages, punitive damages are not classified as non-pecuniary damages either.

It is illogical to assume that the Legislature meant to include punitive damages as “nonpecuniary damages” in NRS 41A.011 when the statute provides a litany of noneconomic compensatory damages but does not include punitive damages. References to punitive damages are frequent throughout chapters 41 and 42. If the Legislature intended to include punitive damages as “other nonpecuniary damages,” it would have done so.

Finally, the grammatical structure of NRS 41A precludes a reading of “noneconomic damages” that includes non-compensatory damages. In the list of what “noneconomic damages” “includes,” there is only one coordinating conjunction (“and”). It appears as part of the compound prepositional phrase modifying the infinitive “to compensate”:

> to compensate *for*
>
> [1] pain,
>
> [2] suffering,
>
> [3] inconvenience,
>
> [4] physical impairment,
>
> [5] disfigurement *and*
>
> [6] other nonpecuniary damages.

NRS 41A.011 (numbering added). If, on the other hand, the Legislature had wanted "nonpecuniary damages" *not* to modify "to compensate"—i.e., to relate back simply to what "'noneconomic damages' includes," the Legislature would have need to add another "and" to make the list grammatical:

> "Noneconomic damages" includes
>
> [a] damages to compensate *for*
>
> [1] pain,
>
> [2] suffering,
>
> [3] inconvenience,
>
> [4] physical impairment, [***and***]
>
> [5] disfigurement
>
> *and*
>
> [b] other nonpecuniary damages.

Id. (bracketed "and" added).

As written, "pain, suffering, inconvenience, physical impairment, disfigurement" without a coordinating conjunction cannot form a complete, coherent list; the list has to extend to the coordinating conjunction. "Damages to compensate" grammatically must include "nonpecuniary damages."

D. Centennial is not Entitled to Apportionment because it was Found Liable for an Intentional Tort

Because the jury found Centennial liable for the intentional breach of its fiduciary duties, it is not entitled to an "apportionment" of fault with the doctors. As discussed, NRS chapter 41A does not supersede the existing statutory and common-law principles that govern fiduciary-duty and other intentional-tort claims. Thus, while NRS 41A.045 allows merely negligent malpractice defendants to apportion liability even among nonparties, NRS 41.141(4) does not. In fact, NRS 41.141(5)(b) provides that an intentional tortfeasor remains jointly liable for the plaintiff's entire damages. *Café Moda v. Palma*, 128 Nev. 78, 84, 272 P.3d 137, 141 (2012) (rejecting apportionment for a defendant found to have committed an intentional tort); *see also Evans v. Dean Witter Reynolds, Inc.*, 116 Nev. 598, 609–10, 5 P.3d 1043, 1050 (2000) ("[A]s a matter of law, intentional tortfeasors, including persons found liable in conversion and persons in conspiracy with them, may not apply credit from settlements by their joint tortfeasors . . . in reduction of judgments against them arising from intentional misconduct.").

III.

THE JURY'S AWARD AND THE DISTRICT COURT'S APPROVAL OF THE PUNITIVE DAMAGES AWARD WAS PROPER

A. The Evidence Supports the Jury's Findings of an Intentional Policy of Medication Administration

The crux of Murray's fiduciary duty claim is that Centennial intentionally outsourced its mediation administration policy to a non-hospital entity, drawn to save personnel costs, though its underinclusive list of time-sensitive medications was bound to cause patients harm. The evidence and testimony at trial supported this claim and Centennial's cost-saving intent.

1. The Hospital did not Draft or Vet the Policy through its Normal Channels

Unlike all the other policies disclosed in this case (38 App. 7796, 38 App. 7798, and 38 App. 7811, Exs. 1–3), which were issued by Centennial's director and approved by the medical director or other officers within the hospital (*see also* 12 App. 2231–34), Centennial neither drafted nor issued its own medication-administration policy. Instead, that policy was created by UHS, a non-hospital holding company. (*Id.* at 2237.)

There was negligible evidence that Centennial's medication administration policy ever underwent any sort of medical review after it was received from UHS. (38 App. 7799, 25 App. 499 (describing the policy as "UHS Medication Administration Procedure" without indicating who within Centennial issued or approved it); *see also* 16 App. 3230–31, 3256.) Andrew Jackson, then Centennial's pharmacy director, nonetheless testified that the policy was internally approved. (*Id.* at 3234.) Irrespective of whether the policy was vetted for patient safety before its implementation, Jackson confirmed that Centennial had the authority to designate Toradol as a time-sensitive medication, but Centennial chose not to. (*Id.* at 3237.)

Centennial let UHS dictate this policy even though it interfered with the orders from doctors and violated the FDA-approved manufacturer's insert.

2. The Policy Interfered with Medical Judgment and was Known to Risk Patients' Lives

In surrendering to the care of a hospital, a patient entrusts the hospital with the administration of all medications. (*Id.* at App. 2209.) The hospital's pharmacists and nursing staff know more about the drugs than the patient, they are in position of authority, and the patient

relies on that superior skill. (16 App. 3241–42.) So when a doctor, exercising medical judgment, orders that medication be administered in accordance with an approved dosing schedule, the hospital must not "institute policies or practices which interfere with the doctor's medical judgment." *Muse*, 452 S.E.2d at 594. When it does, it places the hospital's convenience over the health and safety of its patients, violating the special relationship of trust as a fiduciary.

Centennial let UHS dictate this policy, even though it overrode the FDA's black box warning, interfered with medical providers' medical judgment, and endangered patients:

Centennial's nursing director agreed that nurses must know the information on medication administration, including dosage instructions and any maximum daily dose. (12 App. 2202–05.) The nurses themselves understood the critical importance of a black box warning on dosage in the FDA approved insert. (*See* 14 App. 2798 (Nurse Estopare); *Id.* at 2871, 2872–73 (Nurse Craig); 16 App. 3076 (Nurse Panao); *Id.* at 3115 (Nurse Lavin).) Disregarding these FDA warnings imperils patients. (12 App. 2202–05, 2399.)

Here, although Dr. Arora did not give permission to give more than 120 mg of Toradol in a 24-hour period (14 App. 2739), Centennial's policy overrode that medical determination. (38 App. 7799, 25 App. 4983.) UHS's medication administration policy, as consciously adopted by Centennial, muzzled the FDA black-box warning on Toradol's 120 mg maximum daily dose, the doctors who ordered their nurses to follow it, and the nurses who would otherwise have obeyed the warning and those orders. Instead, according to the policy, for administrative convenience Toradol could be given up to an hour early, exposing a patient such as Ms. Murray to more than 150 mg in less than 24 hours—a toxic overdose. And Centennial's nursing director and pharmacy director both knew it. (*See* 16 App. 3237 (pharmacy director Andrew Jackson admits that Centennial "made a choice not to put Toradol on the time-critical medication list"); 3259–60 (keeping Toradol off the list provides "no benefit whatsoever to the patient").) As a consequence, Dr. Arora's expectation that the black box warning about Toradol's increasing toxicity with too frequent dosing—without any corresponding therapeutic

benefit—yielded to an administrative procedure that allowed staff to ignore those warnings. (14 App. 2680–81, 16 App. 3259–60; Toradol 1–22, 25 App. 4983.)

3. The Profit Motive: The Policy Saved Money

Personnel costs were the driving force behind Centennial's acceptance of the UHS medication administration policy. It allowed staff to put everyone on the same schedule regardless of when medication may have been given. To follow Toradol's warning about the maximum daily dose would create more staff.

Director Jackson

Pharmacy Director Andrew Jackson ties the problem directly to the nurse-to-patient ratio:

> If a nurse has six patients and they have to give all six of them at every 6 hours, they couldn't get it in, they couldn't administer that medication appropriately. So the one hour before, one hour after allows the nurse to be able to give those medications.

(16 App. 3260.)

Director Jones

Nursing Director Janine Jones confirms that a change to the medication administration policy to add Toradol as a time-sensitive medication would require a change to that ratio. Although Director Jones fought the premise of the questions, her testimony indicates that placing a medication on the time-sensitive list translates into a monetary outlay to hire more nurses:

> Q. Okay. And you would agree with me that if Centennial hills Hospital wanted to follow a strict 6-hour guideline on what, for example Toradol—I'm not talking about a 7 a.m. to 7 p.m. or 7 a.m. to 7 a.m. shift. I'm not talking about an hour early, hour late; not counting first doses. If they were going to comply with every 6 hours, you would agree with me they needed more staff; isn't that true?
>
> A. I'm going to disagree, only because that's not how we administer our medications. If we have a q 6 hour [administer every six hours], we have that hour leeway each direction to administer those medications safely.
>
> Q. Okay. But to stay on a 6 hour schedule, you would need more staff; correct?
>
> A. In my opinion, if every medication had to be given exactly on the dot, *we would have to have one to one nurse to patient ratio*.
>
> Q. And—
>
> A. And that's—there's no way you could do that.
>
> Q. Okay. Because it would cut into profits; right?

> A. Oh, it has nothing to do with profits. It's just, you don't have to give that medication exactly on the dot.

(12 App. 2339–40.) The jury, who understood that giving Mrs. Murray doses *more* than six hours apart would not have posed a problem, did not fall for Director Jones's attempt to spin a concern about overdosing (giving too many doses within too short a timeframe) into a strawman about dosing on the dot. The jury could reasonably infer from Director Jones's response that compliance with the FDA approved manufacturer's warning regarding dosage, frequency, and maximum daily dose would have required more nurses.

Waldron

In addition, Centennial's nursing expert, Patricia Waldron, confirmed the concern, however overblown, about needing to hire more nurses. She agreed that nurses needed to be aware of the FDA approved manufacturer's insert regarding the administration of Toradol (dosage, frequency and maximum daily dose), that giving Toradol more frequent than set forth in the black box warning does not increase the efficacy of the medication but will increase the risk of adverse reaction, that the nurses needed to comply with the warnings but nonetheless, at

the same time defended the early administration of Toradol and exceeding the maximum daily dosage all because the applicable administration of medication policy permitted it. (17 App. 3329–34.) She, like Director Jones, tried to claim that complying with the black-box warning would require a one-to-one patient-to-nurse ratio:

> Q And if they were to remove some of those requirements, if they were to tighten it up and make it so you didn’t have this window, you'd have to hire more nurses to comply; wouldn’t you?
>
> A You’d probably have to have a nurse per patient to comply with the way you'd have to give medications.
>
> Q Okay. And that’s a little farfetched, though, wouldn't you agree with me?
>
> A What, having a nurse per patient?
>
> Q Yes.
>
> A Yeah. That’ll never happen.

(17 App. 3333–34.)

Overreactions aside, because Director Jackson had admitted that the policy provided patients “no benefit whatsoever,” the jury had sufficient evidence to conclude that Centennial adopted this policy intentionally with the goal of not having to spend money to hire more staff.

4. Expert Testimony Supported that the Policy was a Breach of the Hospital's Fiduciary Duty

Murray's experts supported this conclusion, as well, making clear that the policy was flawed and unjustifiable and would injure patients. (14 App. 2688–94; 13 App. 2624, 2539–40.)

B. The Evidence Supports the Jury's Finding of an Intentionally Harmful Staffing Policy

The lethal medication administration policy, adopted expressly to save costs, is enough to sustain the jury's verdict on breach of fiduciary duty. Independent of that breach, however, the jury could correctly base its finding on the staffing policy that forbade the assignment of a unit coordinator to Ms. Murray's floor, leading to errors that killed her. This Court should affirm on this independent, alternative ground.

1. Nurse Lavin Gave Expert Testimony on the Role and Necessity of a Unit Coordinator

The district court rejected Murray's staffing-crisis claim in part because "no expert was proffered by Plaintiff to show that the staffing numbers were inappropriate on the floor that day." But to the extent the staffing crisis could be described only by an expert in this field, Nurse Lavin provided that testimony. The Nevada Supreme Court has

repeatedly approved the use of fact witnesses who have expertise to testify as nonretained experts. *See Ford Motor Co. v. Trejo*, 133 Nev. 520, 531, 402 P.3d 649, 657 (2017) (coroner); *FCH1, LLC v. Rodriguez*, 130 Nev. 425, 433, 335 P.3d 183, 189 (2014) (treating physician). Here, Nurse Lavin testified as a qualified registered nurse, the clinical supervisor of the 6th floor (where Ms. Murray was a patient), and the "charge nurse," who would supervise and act as a source for people with questions. (16 App. 3109–11.) There is little question that her credentials, training, and experience qualify her to discuss inadequacies in a hospital's staffing policy. *See Williams v. Eighth Judicial Dist. Court*, 127 Nev. 518, 528, 262 P.3d 360, 366 (2011) (giving examples of the kinds of things within a nurse's experience that the nurse could testify to as an expert).

2. Nurse Lavin Confirmed the Initial Staffing Crisis and that No One Fixed it After her Complaint

Nurse Lavin's contemporaneous direct report confirms the existence of the staffing crisis that she describes, in particular the perils that flow from the hospital's policy of denying a unit coordinator:

> This morning on 4/24/13 *I did not have a unit secretary* due to low census, *the staffing grid does not allow it*.

(38 App. 7816–17 (emphasis added).) She describes the "multiple orders accumulating" and her fear that, because she was having to make up for the absence of the unit coordinator, her "attention was divided inadequately between each role." (*Id.*) Orders for x-rays, fluid cultures, and various lab work were consequently delayed or "not carried out." (*Id.*) (38 App. 7816–17.) Nursing Director Jones indicated on the same incident report that the policy precluded the assignment of a unit coordinator, notwithstanding Nurse Lavin's urgent request:

> I agree that due to census there was no UC [unit coordinator]. Elyse [Lavin] did text me asking for one and I informed her we were short ancillary on all units this day.

(12 App. 2368.) This confirmed not only that hospital policy prevented Nurse Lavin from getting a unit secretary, but that she had to fill that role while also acting as the clinical supervisor and the preceptor for a trainee nurse who, because of the crisis, had been assigned patients too early.

The consequences of that policy are all too clear, including errors and delays related to "patient Ms. Murray" that led to her death.

3. Centennial's Staffing Problems were a Deliberate Policy

Like the medication administration policy, the problem was not one day's shortage; in fact, there was no testimony that there was a nurse "short" in the sense of someone calling in sick or not showing up for work. It was the intentional adoption of a *policy* that forbade Ms. Murray's floor from being adequately staffed with a unit coordinator, even after Ms. Murray's condition became critical.

The reason is simple: Centennial's policy was deliberate; it was Centennial's determination that, no matter the exigency, Ms. Murray's floor did not need a unit coordinator or more nurses. Centennial Hills did not forget to provide a unit coordinator; they claimed their own policy did not require one, even when Ms. Murray was in critical condition.

In rejecting Nurse Lavin's report of the staffing crisis, the district court inappropriately reweighed the evidence, giving credence to Director Jones's testimony that—despite the absence of a unit coordinator, per hospital policy)—it was "ludicrous" and "absolutely not true" that Centennial intentionally understaffed. (33 App. 6795.)

The jury could reasonably have inferred Centennial's intent to place profits above patients in the enactment and enforcement of such a

policy, especially after the crisis was pointed out to them and Centennial declined to budge from its policy of denying a unit coordinator.

C. Punitive Damages Were Properly Based on Centennial's Reprehensible Conduct

1. Centennial Waived the Argument that Employee Conduct was not Ratified

The party challenging the sufficiency of the evidence to support a verdict has to show that the jury, properly applying the court's instructions, could not have reached the result they did. If the defendant thinks that the verdict form is deficient, it needs to object and propose a form that will address the deficiency. *KDS Props., Inc. v. Sims*, 506 S.E.2d 903, 907 (Ga. Ct. App. 1998) ("A party cannot ignore what he thinks to be an injustice, taking his chances on a favorable verdict, and complain later."); *Cf.* NRCP 51(b), (c). By waiting until post-judgment motions to spring the objection on Murray and the Court, Centennial waived the objection, as it does here.

Centennial waived its opportunity to object to Question 11 on grounds that it would not support an award of punitive damages, and it proposed no other question to address the ratification issue. (18 App. 3493, 3495.) Although Centennial could have (but did not) request the

jury to make specific "findings" about who engaged in the wrongful conduct or who approved or ratified it, neither NRS 42.005(3) nor NRCP 49 requires the jury to separately indicate such a finding. It is inherent in their verdict on the amount of punitive damages. The jury was instructed on how to award punitive damages against a corporate employer (Instruction No. 48),[7] and this Court must presume that the jury followed those instructions. *W. Techs., Inc. v. All-Am. Golf Ctr., Inc.*, 122 Nev. 869, 875, 139 P.3d 858, 862 (2006). In failing to object or make a record before submitting the case to the jury, Centennial forfeited any objection to the verdict form.

2. Substantial Evidence Supports Conduct Worthy of Punitive Damages by Centennial's Managing Agents

Regardless, the question provided a sufficient basis for assessing punitive damages. Janine Jones, the director of nursing, and Andrew

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[7] By its terms, NRS 42.007(1) requires only *corporate* defendants to act through an "officer, director or managing agent of the corporation." That condition does not apply to Valley Health, LLC, which is a Delaware limited liability company, not a corporation. Even if it does apply, however, Murray presented substantial evidence of the company's wrongful acts and authorization or ratification of the acts of its employees. (25 App. 4987, 5128.)

Jackson, the pharmacy director, testified that they were employees of Centennial. (*See* 12 App. 2184–85; 16 App. 3229–30.) They were also directors in leadership at the hospital, with the authority to ratify the conduct of the other staff. Their engaging in conduct with "fraud, oppression, or malice toward LaQuinta Murray" would subject the hospital to punitive damages.

As the district court pointed out, no policies were changed after Mrs. Murray's death, and no disciplinary action was taken. (33 App. 6786.) The jury could reasonably have concluded that Centennial was standing firm on this disastrous course.

3. The Jury Followed Correct Instructions on Punitive Damages

Furthermore, the jury was correctly instructed that it could only consider punitive damages under the circumstances outlined in NRS 42.007(1). (*See* 19 App. 3700 (Instruction No. 48).)

As this Court recently held, even where the special verdict form does not set out all of the elements to support an award, this Court will uphold the award if "the jury instruction and verdict form, read together," provide sufficient guardrails on the jury's award. *Motor Coach Indus., Inc. v. Khiabani ex rel. Rigaud*, 137 Nev., Adv. Op. 42, 493 P.3d

1007, 1015 (2021). In *Khiabani*, a product-defect case, this Court upheld a verdict based on a defective failure to warn; even though the verdict form omitted the causation element, the corresponding jury instruction for that claim included causation. *Id.* This Court "conclude[d] that the jury instruction and verdict form, read together, were sufficient to ensure that the jury considered the question of causation for the failure-to-warn claim." *Id.*

So, too, here. While the jury verdict form does not expressly discuss managing agents, the jury instructions clearly did. Moreover, the jury's election to assess punitive damages appeared in a separate special verdict (19 App. 3711), a step that the instructions forbade the jury from taking had the evidence not supported punitive damages against Centennial itself.

D. The Estate Can Recover Full Punitive Damages, as though the Decedent Had Lived

Centennial is correct that Nevada's wrongful-death statute, NRS 41.085, divvies up the items of damage into two actions—one by the heirs and one by the estate.

But just because those damages are assigned to particular parties does not mean that this Court can ignore the statutory direction that

the estate recover "punitive damages[] that the decedent would have recovered if the decedent had lived." NRS 41.085(5)(b). Had Ms. Murray lived, she would have been able to recover punitive damages up to three times her compensatory damages—including all of her special damages and pain and suffering. *See* NRS 42.005(1)(a). That the wrongful-death statute allots the pain-and-suffering damages to the heirs (the same person, here) is no justification for limiting punitive damages based on the amount of compensatory damages, in this case just $10,000 for funeral expenses. Eliminating a substantial portion of the punitive damages that the decedent would have been able to recover would violate NRS 41.100(1)'s promise that "no cause of action is lost by reason of the death of any person." And that would make it an exponentially better financial proposition for malicious defendants to kill, rather than merely injure or disfigure, their victims.

E. The Wrongful Death Statute's Allocation of General Damages to the Heirs does not Limit the Punitive Damages Available to the Estate

Centennial misapplies the general punitive damages cap to supersede the specific wrongful-death statute. Centennial applies NRS 42.005, the general punitive-damages statute, with its reference to a

cap of "[t]hree times the amount of compensatory damages awarded to the plaintiff," and then surmises that the estate is the "plaintiff" with "compensatory damages" of just funeral expenses. This argument, however, disregards the more specific direction given in NRS 41.085 for the unique circumstance of wrongful-death actions. *See Piroozi v. Eighth Judicial Dist. Ct.*, 131 Nev., Adv. Op. 100, 363 P.3d 1168, 1171 (2015) (quoting *State, Dep't of Taxation v. Masco Builder Cabinet Grp.*, 129 Nev., Adv. Op. 83, 312 P.3d 475, 478 (2013)) (a specific statute controls over a more general one). The wrongful-death statute defines the recoverable punitive damages not in reference to the estate's other items compensatory damages but in reference to those that a hypothetical living plaintiff (whose compensatory damages are not split in the manner of the wrongful-death statute) would be entitled to seek.

Further, Centennial misapplies NRS 42.085 to make it seem as though the caveat "but do not include damages for pain, suffering, or disfigurement" is a direct limitation on the calculation of punitive damages. Read as a whole, the statute makes it clear that the estate gets (1) special damages and (2) penalties and punitive damages, but not (3) general damages:

> 5. The damages recoverable by the personal representatives of a decedent on behalf of the decedent's estate include:
>
> (a) Any special damages, such as medical expenses, which the decedent incurred or sustained before the decedent's death, and funeral expenses; and
>
> (b) Any penalties, including, but not limited to, exemplary or punitive damages, that the decedent would have recovered if the decedent had lived,
>
> but do not include damages for pain, suffering or disfigurement of the decedent. The proceeds of any judgment for damages awarded under this subsection are liable for the debts of the decedent unless exempted by law.

NRS 42.085(5). Punitive damages follow this limitation because they are not "damages for pain, suffering, or disfigurement;" rather, they are damages based on the wrongful and reprehensible conduct of a defendant. Nothing in the statute's structure suggests that heirs of the decedent must recover substantially less than what "the decedent would have recovered if the decedent has lived." Centennial's interpretation would give a windfall to a defendant who manages to kill its victim by artificially typing the cap on such damages to special damages.[8]

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[8] Alternatively, particularly in a case where the estate and heirs are represented by the same individual (Mr. Murray), the Court could find that the heirs are entitled to punitive damages on their own claims for

IV.

CENTENNIAL IS NOT ENTITLED TO A NEW TRIAL OR REMITTITUR

A. Murray's Experts Dr. DeBaun and Dr. Schwimmer were Qualified

The district court properly allowed Dr. DeBaun and Dr. Schwimmer to discuss the standard of care applicable to hospitals and their staff, including nurses. Dr. Schwimmer and Dr. DeBaun established their qualifications through their extensive experience with nurses. (13 App. 2491–94; 15 App. 2916–17.) *See Williams v. Eighth Judicial Dist. Ct.*, 127 Nev. 518, 521, 262 P.3d 360, 362 (2011) (rejecting rigid barriers to qualification and holding that a nurse could acquire the qualifications to testify about medical causation through experience or training).

B. Dr. DeBaun and Dr. Schwimmer Properly Applied the Opinions that they had Previously Disclosed

Disclosure of expert opinions under Rule 16.1 serves to alert the opposing party to the topics and issues that each expert will address.

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grief or sorrow, loss of probable support, companionship, society, comfort and consortium. In that case, there would be no issue under NRS 42.005 because the "plaintiff" seeking punitive damages is the same individual with the compensatory damages award. No division was necessary in this case because Mr. Murray is entitled to both the damages of the heirs and those of the estate, as its administrator.

The rule does not require an expert's testimony at trial to exactly match the report or to disregard evidence that came to light later. *Khoury v. Seastrand*, 132 Nev., Adv. Op. 52, 377 P.3d 81, 92 (2016); NRS 50.285(1).

Here, at the time Dr. DeBaun and Dr. Schwimmer submitted their reports and were deposed, Centennial had not disclosed the medication-administration policy. Centennial cannot take advantage of its delay to limit Murray's experts.

In any case, their reports adequately put Centennial on notice that its administration of Toradol was being critiqued and would be a major issue at trial. Dr. Schwimmer and Dr. DeBaun each testified consistent with their reports that the improper administration of Toradol reflected a failure not just of the treating doctor but of Centennial itself, including its nurses and pharmacy. (13 App. 2540–41, 2624; 14 App. 2680; 15 App. 2929–30.)

Centennial's own counsel elected to open the door to a discussion of the medication-administration policy by cross-examining Dr. DeBaun with it. (13 App. 2622–24.) In representing that the nurses acted in accordance with hospital policy, Centennial allowed Dr. DeBaun to opine

that such a policy, by contravening the black box warning, was "flawed." (*Id.*) Centennial did not object or move to strike Dr. DeBaun's answer.

Similarly, Centennial did not object when Dr. Schwimmer answered a hypothetical question (that dosing Toradol an hour earlier would be fine) by opining that Toradol cannot be given more frequently than every six hours, and that "it's the hospital and pharmacy's responsibility to make sure that medications are not given by the nurses even if there' s a . . . procedure that violates the black box warning." (15 App. 2993.) Centennial elicited Dr. Schwimmer's response without objection:

> [T]he policy for the institution, it should be a medication that you can't give . . . more frequently than every 6 hours. That's the way it should be labeled, per the hospital, per the pharmacy. *So if the nurses were doing something incorrect based upon the policy, it's the hospital and the pharmacy that's responsible for the policy*.

(*Id.* at 2998 (emphasis added).)

These opinions were consistent with their expert reports and depositions; that Centennial turned out to have exactly such a policy is not a deficiency in the expert disclosures. The district court was correct to allow their testimony.

C. The Jury Reached its Verdict Based **on the Evidence, not Passion or Prejudice**

1. Attorney Argument Rarely Justifies a New Trial

Not every instance of attorney misconduct warrants a new trial. *Bayerische Motoren Werke Aktiengesellschaft v. Roth*, 127 Nev. 122, 133, 252 P.3d 649, 656 (2011). The misconduct has to be considered in context, including whether the misconduct is isolated or pervasive. *Michaels v. Pentair Water Pool & Spa*, 131 Nev. 804, 823, 357 P.3d 387, 395 (Ct. App. 2015). If the party seeking a new trial timely objected to the misconduct, the party has to show that the district court should have sustained the objection and that "an admonition to the jury would likely have affected the verdict in favor of the moving party." *Lioce v. Cohen*, 124 Nev. 1, 19–20, 174 P.3d at 970, 982 (2008). Without a timely objection, the error is usually waived, unless the party demonstrates plain and prejudicial error: "'no other reasonable explanation for the verdict exists' except for the misconduct." *Michaels*, 357 P.3d at 387 (quoting *Lioce*, 124 Nev. at 19, 174 P.3d at 82).

2. Asking the Jury to "Send a Message" to Centennial was not Misconduct, Much Less Prejudicial Misconduct

Centennial argues that Murray's counsel committed misconduct

by asking the jury to fulfill its role as the community's conscience and to "send a message" to Centennial. (Centennial Opening Brief at 53.) But an argument to "send a message" to a particular defendant is "not prohibited so long as the attorney is not asking the jury to ignore the evidence." *Pizarro-Ortega v. Cervantes-Lopez*, 133 Nev. 261, 269, 396 P. 3d 783 (2017); *accord Gunderson v. D.R. Horton, Inc.*, 130 Nev. 67, 78, 319 P.3d 606, 614 (2014). And in both instances, Murray's counsel immediately clarified that the jury should act on the "evidence and testimony, not to disregard it." (18 App. 3519, 3563.)

Additionally, Centennial did not object. The "reasonable explanation for the verdict" is the evidence of Centennial's conscious disregard toward Ms. Murray's health and safety, not the harmless argument of Murray's counsel. *See Licoce*, 124 Nev. at 19, 174 P.3d at 82.

3. Murray's Counsel Never Asked the Jury to Punish UHS

The district court correctly overruled Centennial's objection to Murray's argument that Centennial should not have adopted UHS's medication-administration policy. (18 App. 3554.) The jury heard evidence that this policy was dangerous for omitting Toradol from the list of time-critical medications, and Centennial had the ability to add it but

decided not to. (16 App. 3237; 13 App. 2624; *see also* 13 App. 2540–46; 14 App. 2680–81, 2696–97.)

Centennial now believes that this was a ploy to get the jury to punish a nonparty via the award against Centennial (Centennial Opening Brief at 54 (citing *Phillip Morris USA v. Williams*, 549 U.S. 346, 353–54 (2007)), but nothing in the evidence or argument supports that. Murray consistently criticized *Centennial* for accepting the policy with minimal or no medical review; indeed, the jury would have understood that, as a non-hospital, UHS lacks both the expertise and the legal duties that a hospital has. The fault is Centennial's, not UHS's, for not adding Toradol to the list of seven time-critical medications:

> They [Centennial's pharmacy] chose what's going on the list. And the reason for this it was the nurses, the pharmacists at Centennial Hills Hospital's decision to choose the convenience over patient safety.

(18 App. 3555.)

V.

CENTENNIAL WAIVED ITS ARGUMENT THAT PREJUDGMENT INTEREST SHOULD NOT HAVE BEEN AWARDED

Centennial did not address any argument as to prejudgment interest until long after the post-judgment motions had been briefed, the district court had issued its decision confirming the original judgment, and the parties submitted proposed written orders to memorialize the court's decision.

Centennial's attempt to have the "amended judgment" reject the plaintiffs' verdict form (which would have distinguished between past and future damages as Centennial now contends is necessary), and its failure to timely raise the issue of prejudgment interest in post-judgment motions is improper.

A. Centennial Waived Any Objection to Prejudgment Interest

The time for Centennial to raise objections to the February 21, 2019 judgment was in post-judgment motions. *See* NRCP 6(b) (2018 version) (barring extensions for motions under Rules 50(b), 59(b), and 59(e)); *accord* NRCP 6(b)(2) (2019 version). It did not. Even after the

district court granted relief, Centennial never questioned that prejudgment interest would run on all of plaintiffs' compensatory damages. The issue is waived. *See Benson v. St. Joseph Reg'l Health Ctr.*, 575 F.3d 542, 546–48 (5th Cir. 2009) (declining to review as unpreserved an issue that was not raised in the appellant's first Rule 59(e) motion).

B. The Prejudgment Interest in the Original Judgment is Correct

Centennial also wants the forfeited issue to seem clear-cut by suggesting that the jury's verdict improperly commingles past and future damages. (35 App. 7047.) What Centennial omits is that that's a problem of Centennial's own making: plaintiffs' proposed verdict (the same one that Centennial rejected because it asked the jury to separately assess the damages from Centennial's breach of fiduciary duty) would have expressly separated the only item of future damage: the "[f]uture grief or sorrow reasonably certain to be experienced."[9] (*Id.* at App.

[9] Loss of consortium and loss of financial support or household services are *past* damages: First, the jury instructions and verdict form expressly directed the jury only to award for "grief or sorrow reasonably certain to be experienced in the future." (Jury Instruction No. 45.) Everything else was a loss already "suffered" (past tense). (*Id.*) Second, "in the case of personal injury, prejudgment interest is to be awarded for the loss of earning capacity, even though it is future income that is affected by that loss." *Commonwealth v. Johnson Insulation*, 682 N.E.2d

7073–78.) In insisting instead on a form that erased that distinction, Centennial waived its objection to the award of prejudgment interest on the entire compensatory verdict.[10]

VI.

THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN AWARDING ATTORNEY FEES AND COSTS

Because claims for attorney fees under NRCP 68 are fact intensive, this Court will not disturb these awards in the absence of an abuse

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1323, 1334 (Mass. 1997), *cited with approval in Shuette v. Beazer Homes Holdings Corp.*, 121 Nev. 837, 866 n.105, 124 P.3d 530, 550 n.105 (2005) (looking to Massachusetts law in the interpretation of NRS 17.130), *and quoted in Brayman v. 99 W., Inc.*, 116 F. Supp. 2d 225, 236 (D. Mass. 2000), *aff'd*, 26 F. App'x 24 (1st Cir. 2002). Here, plaintiffs' expert reduced his loss-of-support calculation to present value for precisely that reason. (16 App. 3168 ("I was asked to calculate the *present value* of the loss in financial support to the family of Ms. LaQuinta Murray as a result of her death.") (emphasis added).) *See Carey v. Gen. Motors Corp.*, 387 N.E.2d 583, 588–89 (Mass. 1979) ("the present value of a sum sufficient to compensate the plaintiff" for "future loss of earning capacity" was properly treated as past damages for purposes of applying prejudgment interest on the entire verdict). These are past damages as a matter of law.

[10] Regardless, "when there is nothing in the record to suggest that future damages were included in the verdict, prejudgment interest on the entire verdict is allowed." *Albios v. Horizon Cmties., Inc.*, 122 Nev. 409, 428, 132 P.3d 1022, 1035 (2006). As the only evidence of future damages was on grief and sorrow, at most prejudgment interest would be reduced from that $7,000,000 award, not from the $6.7 million in loss of support and consortium.

of discretion. *Wynn v. Smith*, 117 Nev. 6, 13, 16 P.3d 424, 428 (2001). In exercising its discretion, the trial court must carefully consider the following factors:

> (1) whether the plaintiff's claim was brought in good faith; (2) whether the defendants' offer of judgment was reasonable and in good faith in both its timing and amount; (3) whether the plaintiff's decision to reject the offer and proceed to trial was grossly unreasonable or in bad faith; and (4) whether the fees sought by the offeror are reasonable and justified in amount.

Beattie v. Thomas, 99 Nev. 579, 588–89, 668 P.2d 268, 274 (1983) (finding that the district court abused its discretion because it only found that the settlement offer was reasonable and in good faith and did not make findings on the other factors). "[U]nless the trial court's exercise of discretion [in evaluating the *Beattie* factors] is arbitrary or capricious, this court will not disturb the lower court's ruling on appeal." *Schouweiler v. Yancey Co.,* 101 Nev. 827, 833, 712 P.2d 786, 790 (1985).

"Although explicit findings with respect to these factors are preferred, the district court's failure to make explicit findings is not a per se abuse of discretion." *Wynn*, 117 Nev. at 13, 16 P.3d at 428. "If the record clearly reflects that the district court properly considered the *Beattie* factors, we will defer to its discretion." *Id.*

A. The District Court Considered Every *Beattie* Factor in Finding that Murray Should be Awarded Attorney Fees

Here, the district court explicitly considered every factor required by *Beattie* and made a finding in its Order. (32 App. 6520–6526.) The court specifically found that the "Plaintiffs' offer was reasonable and in good faith in both its timing and amount." (*Id.* at 6524.) The court also listed the reasons that it found the offer to be in good faith. Further, the court explicitly found that "Defendant's rejection of the offer was in bad faith and/or grossly unreasonable," and listed the support for its findings, concluding that Defendant knew the evidence and knew what claims Plaintiff was seeking. (*Id.*)

The court then considered the fourth factor using the *Brunzell v. Golden Gate National Bank* analysis to determine if the fees sought were reasonable and justified. (*Id.* at 6525 (citing 85 Nev. 345, 455 P.2d 31 (1969)). The court explicitly referenced the *Brunzell* factors and expressly applied several of them in its reasonableness determination, including the role of competent performance, skill, education, and the work actually performed by the lawyer in preparation and during the course of trial. (*Id.*) The court found "Plaintiffs' counsel are experienced

trial attorneys with the knowledge and skill to try difficult and complex cases" and that "the effort and work performed by Plaintiffs['] counsel resulted in a substantial verdict." (*Id.*) Unlike in *Beattie*, the court properly considered all four factors in making its determination. The court's conclusions were reasonable, measured, and based on the evidence presented in the parties' briefs; just because Centennial disagrees with the decision does not make it arbitrary and capricious.

B. The District Court did not Abuse its Discretion in Awarding Plaintiffs the Full Amount of Expert Witness Fees

Similar to attorney fees, the district court should consider the factors outlined in *Frazier v. Drake*, 131 Nev. 632, 650–51, 357 P.3d 365, 377–78 (Ct. App. 2015), in determining whether to award plaintiff's full attorney fees. These factors include

> the importance of the expert's testimony to the party's case; the degree to which the expert's opinion aided the trier of fact in deciding the case; whether the expert's reports or testimony were repetitive of other expert witnesses; the extent and nature of the work performed by the expert; whether the expert had to conduct independent investigations or testing; the amount of time the expert spent in court, preparing a report, and preparing for trial; the expert's area of expertise; the expert's education and training; the fee actually charged to the party who retained the expert; the fees tradition-

> ally charged by the expert on related matters; comparable experts' fees charged in similar cases; and, if an expert is retained from outside the area where the trial is held, the fees and costs that would have been incurred to hire a comparable expert where the trial was held.

Id. Not only did the district court consider these factors, it made explicit findings as to each and every factor. (33 App. 6747–6751.) None of those findings were arbitrary and capricious; the record reflects that each finding was carefully thought out and considered by the court. Each finding was also supported by evidence that the court found credible. That Centennial does not agree with the district court's findings does not make said findings unreasonable or an abuse of discretion. This Court should not disturb the district court's ruling on attorney fees and expert witness costs; Centennial has made no showing that the court abused its discretion.

CONCLUSION

Although Mrs. Murray's treatment at Centennial was riddled with errors, Mrs. Murray did not die merely because of a mistake in medical judgment. As the jury found, she died because, after placing her life in Centennial's hands, Centennial intentionally abused that trust with policies designed to maximize profits at her expense. Centennial did

not want to pay for a unit coordinator, despite being aware of the need, and it did not want to pay for the extra staff that would be required to actually administer a time-critical drug like Toradol in accordance with those who *had* exercised medical judgment. Far from mere professional negligence, Centennial's calculated, financially-driven acts were an intentional, malicious breach of its fiduciary duties.

For these reasons, this Court should affirm the judgment.

Dated this 25th day of October, 2021.

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CERTIFICATE OF COMPLIANCE

1. I certify that this brief complies with the formatting, typeface, and type-style requirements of NRAP 32(a)(4)–(6) because it was prepared in Microsoft Word 2010 with a proportionally spaced typeface in 14-point, double-spaced Century Schoolbook font.

2. I certify that this brief exceeds the type-volume limitations of NRAP 32(a)(7) because, except as exempted by NRAP 32(a)(7)(C), it contains 17,528 words.

3. I certify that I have read this brief, that it is not frivolous or interposed for any improper purpose, and that it complies with all applicable rules of appellate procedure, including NRAP 28(e). I understand that if it does not, I may be subject to sanctions.

Dated this 25th day of October, 2021.

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