

IN THE CIRCUIT COURT OF OUTAGAMIE COUNTY

STATE OF WISCONSIN

SCOTT SCHARA, individually, and as the
Administrator of the Estate of Grace Schara,

Plaintiff,

vs.

Case No. 23-CV-345

ASCENSION HEALTH, ASCENSION
NE WISCONSIN, INC. d/b/a ASCENSION NE
WISCONSIN - ST. ELIZABETH CAMPUS,
GAVIN SHOKAR, M.D., DAVID BECK, M.D.,
DANIEL LEONARD, D.O., KARL BAUM, M.D.,
RAMANA MARADA, M.D., HOLLEE MCINNIS, R.N.,
ALISON BARKHOLTZ, R.N., WI INJURED PATIENTS
AND FAMILIES COMPENSATION FUND,
JOHN DOES 1, 2, 3, 4 - MEDICAL PROVIDERS,

Defendants.

Video-Recorded Deposition of GAVIN SHOKAR, M.D.

Wednesday, May 22nd, 2024

1:07 p.m. - 6:21 p.m.

at

St. Elizabeth Hospital
1506 South Oneida Street
Appleton, Wisconsin

Job No. 166818B

Stenographically Reported by Rosanne E. Pezze, RPR/CRR
Certified Realtime Reporter

1 Video-Recorded Deposition of GAVIN
2 SHOKAR, M.D., a witness in the above-entitled
3 action, taken at the instance of the Plaintiffs,
4 pursuant to Chapter 804 of the Wisconsin Statutes,
5 pursuant to Notice, before Rosanne E. Pezze,
6 RPR/CRR, Certified Realtime Reporter and Notary
7 Public, State of Wisconsin, at 1506 South Oneida
8 Street, Appleton, Wisconsin, on the 22nd day of
9 May, 2024, commencing at 1:07 p.m. and concluding
10 at 6:21 p.m.

11 A P P E A R A N C E S:

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1 A P P E A R A N C E S (continued):

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ALSO PRESENT: Ms. Deborah Schmidt, Risk
Manager
Mr. Scott Schara
Ms. Megan Sczygelski,
Videographer

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(Original exhibits attached to Original transcript; copies of exhibits are attached.)

R E Q U E S T S

(None.)

1 TRANSCRIPT OF PROCEEDINGS

2

3 VIDEOGRAPHER: Good afternoon. We are
4 on the record. Today's date is May 22nd, 2024 and
5 the time is 1:07 p.m. This is the video-recorded
6 deposition of Gavin Shokar, M.D. in the matter of
7 Scott Schara versus Ascension Health, et al., Case
8 No. 23-CV-345 venued in the state of Wisconsin,
9 Circuit Court of Outagamie County.

10 This deposition is being held at
11 St. Elizabeth Hospital, 1506 South Oneida Street
12 in Appleton, Wisconsin. The reporter's name is
13 Rosanne Pezze. My name is Megan Sczgeliski. I'm
14 the certified legal videographer. We are with
15 Lexitas Legal. Would the attorneys present please
16 introduce themselves and the parties they
17 represent, after which the court reporter will
18 swear in the witness.

19 MR. FRANCKOWIAK: Attorney Jason J.
20 Franckowiak on behalf of defendants St. Elizabeth
21 Hospital, Ascension and the nurses.

22 MR. POJE: Jason Poje, P-O-J-E, from
23 Corneille Law Group appearing on behalf of Dr.
24 Marada.

25 MR. GUSE: Attorney Randall Guse of the

1 Otjen Law Firm appears on behalf of Dr. Baum, Dr.
2 Beck, and Dr. Shokar.

3 MR. PFLEIDERER: Attorney John
4 Pfleiderer from Mendenhall Law Group appearing on
5 behalf of plaintiff.

6 MR. EDMINISTER: Attorney Michael
7 Edminister appearing on behalf of the plaintiff.

8 MR. BIRNBAUM: Attorney Aaron Birnbaum
9 appears via zoom on behalf of Dr. Daniel Leonard.

10 MR. GILL: Attorney Jeremy Gill appears
11 on behalf of the Fund.

12 GAVIN SHOKAR, M.D., having been first
13 duly sworn on oath, was examined and testified as
14 follows:

15 E X A M I N A T I O N

16 BY MR. PFLEIDERER:

17 Q Good afternoon, Dr. Shokar. As you heard on the
18 read-off, my name is John Pfleiderer. I'm an
19 attorney. I represent the plaintiff in this
20 matter, as you just heard.

21 A **Um-hmm.**

22 Q Would you please state your full name for the
23 record.

24 A **Yes. It's Gavin Singh Shokar.**

25 Q And Dr. Shokar, are you familiar with the case of

1 Grace Schara versus Ascension Health?

2 **A I am.**

3 Q Are you aware that you are a defendant in that
4 case?

5 **A I am.**

6 Q Okay. Did you do anything to prepare for your
7 deposition today?

8 **A Clarify.**

9 Q You are currently at a deposition.

10 Are you aware of that?

11 **A Yes.**

12 Q Did you do anything to prepare to -- prepare for
13 your --

14 **A I reviewed -- I reviewed the documents sent by
15 Dr. -- by Randall Guse here and his office, and
16 kind of reviewed those notes, yeah --**

17 Q Okay.

18 **A -- pertaining to the case.**

19 Q Okay. Did you review anything else?

20 **A I did not.**

21 Q Now, I'm not interested in any kind of notes or
22 communications that you've had with Mr. Guse or
23 any kind of comments that he would have put on any
24 of those documents that were directed towards you.

25 But without sharing any of those

1 details, would you please tell me what documents
2 you reviewed.

3 **A I reviewed the medical record documents, which**
4 **included my notes from the 12th and the 13th.**
5 **There was a few of them; the morning note, a**
6 **conversation note from the afternoon on the 12th,**
7 **the 13th, my medical note, and then the death**
8 **summary, as well as some lab orders, vital signs,**
9 **that kind of stuff that were per the document that**
10 **I was sent.**

11 Q And when you say the death summary, are you
12 referring to the discharge summary?

13 **A Correct, yes.**

14 Q And you said you reviewed labs, vitals, and was
15 there a third thing?

16 **A Labs, vitals, nursing notes that were sent to me,**
17 **yes.**

18 Q And at first there you said you had reviewed
19 medical record documents.

20 The medical record documents that
21 you reviewed, are those the ones that you just
22 described?

23 **A Correct.**

24 Q Were there any medical record documents that you
25 reviewed that you did not just describe?

1 **A No.**

2 MR. GUSE: One clarification. You were
3 also sent the consent to treat, and you reviewed
4 that.

5 **A Correct.**

6 BY MR. PFLEIDERER:

7 Q When you refer to the consent to treat, are you
8 referring to the form which gives general consent
9 upon entering the hospital and also the financial
10 agreement?

11 **A I believe so. It was a document sent to me**
12 **pertaining to that, yes.**

13 Q Did the document that you reviewed, did it have a
14 signature on it?

15 **A I don't believe so.**

16 Q Did it have anything written in a place where a
17 signature might be found?

18 **A I'm not sure. I just saw -- I saw a printed name,**
19 **but I -- honestly, I kind of skimmed the document**
20 **as it wasn't really pertaining -- it was something**
21 **that was introduced to me recently.**

22 Q So you had not seen that document before. It was
23 presented to you to review prior to this
24 deposition?

25 **A Correct.**

1 Q Okay. Not including any conversations with your
2 attorney, Mr. Guse, or any other of your
3 attorneys, have you ever discussed that document
4 with anyone else?

5 A No.

6 Q In regard to the labs that you reviewed, do you
7 remember which labs you reviewed in preparation
8 for this deposition?

9 A Um, let me think. It was not particular lab
10 values as far as I recall. It was more the lab
11 orders and what was ordered at what times. A
12 large portion of those was labs that were
13 associated with tube feeding orders. There was
14 ABG orders. But again, I don't recall reading any
15 of the actual lab values apart from what had been
16 listed in my notes.

17 Q And when you say notes, you're referring to
18 your --

19 A My notes.

20 Q -- progress notes?

21 A Correct, yes.

22 Q Not any personal notes that you would have made?

23 A Correct, yes. Of the documents that I reviewed,
24 which were the only documents that I had reviewed.

25 Q Then in regard to vitals, do you remember

1 specifically which vitals you reviewed in
2 preparation for this deposition?

3 A I reviewed the vitals that were listed in my
4 progress notes as well as the vitals that were
5 listed in the nursing or the supplementary data
6 from the package that Mr. Guse sent me from, I
7 believe, the nursing parts of the document. Yeah.

8 Q When you say -- did you say supplementary data or
9 supplementary notes that were provided to you?

10 A It -- so the document that was sent to me had my
11 notes in it, and then it had a dozen -- a couple
12 dozen pages of, like, orders, and nursing, you
13 know, what the nurses wrote in little sentences.
14 And there was, like, two or three pages in that
15 that had, like, in the nurse's section the, you
16 know, the data that they put down, which would be
17 blood pressures. That was really the only vitals
18 that I could see in that document.

19 Q And last, you said that you reviewed nursing
20 notes, correct?

21 A Correct. In the document that was sent to me
22 there was, again, about two pages or so of, you
23 know, little sentences of updates that the nurses
24 would put through the day.

25 Q Sure. And were those nursing notes primarily

1 related to dates of service in which you were
2 treating Grace Schara?

3 **A Correct. There was -- there was, I believe, a**
4 **couple from like the 10th or the 11th, which I was**
5 **not treating Grace at that time.**

6 Q Okay. And I apologize, because I did not go there
7 first.

8 You did treat Grace Schara in
9 October of 2021 at St. Elizabeth Hospital?

10 **A I did.**

11 Q Okay. So we're going to loop back sort of to the
12 intro section now.

13 You are a medical doctor, correct?

14 **A Correct.**

15 Q M.D.?

16 **A Correct.**

17 Q And achieving a medical doctor requires formal
18 education, correct?

19 **A Correct.**

20 Q Where did you attend high school at?

21 **A I went to Iroquois Ridge High School in Oakville,**
22 **Ontario in Canada.**

23 Q Did you finish high school there?

24 **A I did.**

25 Q And did you attend undergrad?

1 **A** **I did.**

2 **Q** Good for you.

3 Did you begin -- I'm assuming you
4 went to medical school?

5 **A** **I did.**

6 **Q** And did you begin medical school immediately after
7 you graduated from undergrad?

8 **A** **I did.**

9 **Q** And where did you go to medical school at?

10 **A** **I went to Ross University School of Medicine.**

11 **Q** Is that in Michigan?

12 **A** **No.**

13 **Q** Okay. Where is that at?

14 **A** **That's a -- their primary base is in Dominica in**
15 **the West Indies; Portsmouth, Dominica.**

16 **Q** Dominica. Okay. And I think I know, but can you
17 just remind me where the West Indies are?

18 **A** **If you take a flight from Miami or Antigua and you**
19 **go south of there, it's kind of in the Atlantic**
20 **Ocean.**

21 **Q** Sort of by the Caribbean?

22 **A** **Caribbean, correct.**

23 **Q** Why did you go there?

24 **A** **It was a very good option for me.**

25 **Q** What do you mean by that?

1 **A** **I was on an off-cycle. To attend a medical school**
2 **in Canada or the U.S., I would have to wait two**
3 **years. They were offering a trimester entrance in**
4 **January. I made the decision to go to med school,**
5 **and it was the only place I interviewed at,**
6 **actually, and was accepted at so that I can begin**
7 **medical school without having to wait another**
8 **couple of years.**

9 **Q** **Um-hmm.**

10 **A** **Because I had switched my plan from going into**
11 **doing a master's and a Ph.D. first.**

12 **Q** **What year did you begin medical school at -- you**
13 **said Dominica?**

14 **A** **Ross University School of Medicine is the -- yeah,**
15 **is the school.**

16 **Q** **When did you begin at Ross?**

17 **A** **That was in 2008, January.**

18 **Q** **And did you finish medical school at Ross?**

19 **A** **I did.**

20 **Q** **Did you ever attend any other medical school?**

21 **A** **I did not.**

22 **Q** **And what year did you finish med school at Ross?**

23 **A** **2012.**

24 **Q** **Did you participate in a residency following**
25 **graduation from medical school?**

1 **A I did.**

2 Q And where did you participate?

3 **A I went to Southern Illinois University in Decatur,**
4 **Illinois.**

5 Q When would that residency have started? In 2012?

6 **A Correct.**

7 Q Was there a specialization affiliated with that
8 residency?

9 **A Yes. It was a family medicine residency program.**

10 Q Okay. Did you complete that residency?

11 **A I did.**

12 Q When did you complete it?

13 **A 2015.**

14 Q When you finished the residency, was it still
15 family medicine?

16 **A Correct.**

17 Q Okay. What did you do after you completed,
18 professionally, what did you do professionally
19 after you completed your residency in 2015?

20 **A I moved back to Canada, Toronto, and developed or**
21 **built up a solo practice, from which then I**
22 **transitioned to a group practice and then decided**
23 **to go to hospital-based practice.**

24 Q So you would have started your solo practice in
25 2015?

1 A Correct.

2 Q When did you join the group practice?

3 A 2016.

4 Q Okay. You joined an existing group practice?

5 A Correct. I migrated my office to an existing
6 group practice. It was a better model of care
7 than -- than solo practice.

8 Q What do you mean by a better model of care?

9 A In Ontario, there's several models of care.
10 There's fee-for-service care, there is FHGs, or
11 family health groups, and there are -- there is
12 another model. You know, these are kind of
13 exclusive for Canada.

14 The family health group offers a
15 more robust coverage for your patients to be seen
16 after hours and before hours, more covering
17 support with other physicians since you
18 collaborate with four other physicians. So it was
19 a more beneficial structure to offer more
20 services. It allowed for a collaborative venture,
21 you know, to hire a nurse so that they can, you
22 know, offer nursing services as well.

23 Q Sure.

24 A So it was just -- that was the reason for that.

25 Q When did you begin hospital practice?

1 **A** **2018.**

2 **Q** **Sounds like group practice was pretty good. Why**
3 **did you switch to hospital practice?**

4 **A** **I had an affinity for hospitalist-based practice**
5 **during residency. I was quite good at it. I was**
6 **told to go into hospitalist-based practice. I**
7 **decided to return home instead. Outpatient family**
8 **medicine practice was something that was more**
9 **attainable when you're going from the U.S.**
10 **training medical system back to Canada.**

11 **And then during that time period I**
12 **realized my colleagues were right, I was better**
13 **off doing hospitalist-based medicine, and I**
14 **decided to reenter that field.**

15 **Q** **Where did you begin your hospital-based practice?**
16 **Who employed you, I mean?**

17 **A** **Sure. Sound Physicians in Tyler, Texas was my**
18 **workplace, at Christus Mother -- Christus Trinity**
19 **Mother Frances Hospital.**

20 **Q** **Is that a Catholic hospital?**

21 **A** **It is.**

22 **Q** **And what -- you said you were doing outpatient**
23 **family medicine?**

24 **A** **I was doing -- you mean in Canada?**

25 **Q** **No, at the Catholic hospital in Texas.**

1 A No. I was an inpatient hospitalist physician.

2 Q When you say hospitalist, what do you mean by
3 that?

4 A The hospitalist is a field of medicine in which
5 you exclusively see patients who are admitted to
6 the hospital. It's a designated field, you know,
7 to take care of more complex general care cases of
8 varying -- you know, covering all specialties for
9 anybody coming in, they need an attending, you
10 know, to quarterback their care. And so that's
11 what is provided for anybody who doesn't have a
12 family physician or internal medicine doctor
13 coming into the hospital to round on their
14 inpatients, which doesn't happen everywhere.

15 Q If this question makes sense to you, how would you
16 compare a hospitalist with an intensivist?

17 A The general -- you know, I would -- my definition
18 of it would be an intensivist is somebody who is
19 critically care trained who generally practices in
20 the ICU setting and is usually trained in
21 pulmonary critical care or anesthesia critical
22 care.

23 As far as the hospitalist is
24 usually trained in family medicine or internal
25 medicine and, you know, the scope of what they do

1 is a little -- is a bit different because of --
2 because of the types of patients they see.

3 Q Sure.

4 A Yeah.

5 Q Did I ask you if you had any board certifications?

6 A You did not.

7 Q Okay. Do you have any board certifications?

8 A Yes, I am board certified in family medicine.

9 Q Any others?

10 A That is all.

11 Q When did you become board certified in family
12 medicine?

13 A 2015, the same summer that I graduated from
14 residency.

15 Q Okay. So you're working at a -- you started
16 working at a Catholic hospital there in Texas in
17 2018?

18 A Correct.

19 Q How long did you work at that hospital for?

20 A I was there until September 2020.

21 Q September 2020.

22 Did you ever work in the ICU while
23 you were at that hospital?

24 A Yes. It was an open ICU.

25 Q What does that mean?

1 **A** **It means that generalist physicians also see**
2 **patients in the ICU in collaboration with a**
3 **intensivist.**

4 **Q** Am I correct in understanding that the intensivist
5 would sort of oversee the work of that hospitalist
6 physician?

7 **A** **No.**

8 **Q** Okay. What would be the relationship? You said
9 in collaboration with the intensivists.

10 What would be the relationship
11 between that intensivist and the hospitalist, in
12 your experience at the Texas hospital?

13 **A** **Sure, sure. The general collaboration as exists**
14 **amongst all hospitals, most hospitals, I would**
15 **say, in general, if a patient is ventilated,**
16 **mechanically ventilated, intubated, the ICU**
17 **physician, a/k/a the intensivist, is the, you**
18 **know, pretty much the main physician that sees**
19 **that patient. And in those scenarios the**
20 **generalist physician either no longer continues**
21 **rounding or continues rounding depending on the**
22 **hospital.**

23 **Q** Did you say the generalist physician?

24 **A** **Yes. That is --**

25 **Q** Are you using that interchangeably with a

1 hospitalist physician?

2 **A Correct. Correct. Sorry.**

3 Q No problem.

4 **A Would you prefer --**

5 Q No. I just want to make sure -- you can use
6 whatever words you want.

7 **A Okay. In non-vented patients, the hospitalist**
8 **is -- still remains as, you know, kind of like the**
9 **quarterback of the manager of the care with the**
10 **consultation from the intensivist.**

11 Q Okay. What was the last part? In conversation --

12 **A With a consultation -- in consultation with the**
13 **intensivist. I usually don't use the term**
14 **"intensivist," by the way. I use the critical**
15 **care doctor, so I'll use those interchangeably.**

16 Q Sure. No problem.

17 Am I correct in understanding that
18 for a generalist physician to provide care in the
19 ICU at this hospital in Texas, there would need to
20 be collaboration with a critical care physician?

21 **A Yes.**

22 Q Okay.

23 **A Um-hmm.**

24 Q And I know this is just the converse, but a
25 generalist physician could not provide treatment

1 in the ICU without consultation with an ICU
2 doctor?

3 **A The ICU domain is usually an ICU physician's**
4 **domain. I mean, that's their field.**

5 **Q Yeah.**

6 **A The structure of that unit is different from the**
7 **general wards. They have much more closer**
8 **critical care or nursing one-to-one needs,**
9 **one-to-two needs, which means one nurse to one**
10 **patient, one nurse to two patients, and that has**
11 **oversight with an ICU or critical care physician.**

12 **Q Yep. In going back to your job change September**
13 **of 2020, did you go to another hospital?**

14 **A Yes.**

15 **Q Okay. What hospital did you go to?**

16 **A I came here to St. Elizabeth, in October of 2020**
17 **is when I started.**

18 **Q Can you describe your job title or position at St.**
19 **Elizabeth when you got to St. Elizabeth in October**
20 **of 2020?**

21 **A Yes. It was the same, you know, job description.**
22 **It was a hospitalist physician. Same rough role**
23 **as what I was doing before.**

24 **Q You said a rough role. Why do you say that?**

25 **A My job changed a little bit in Texas. I was**

1 **selected to be in the Louis & Peaches Heart**
2 **Hospital --**

3 THE STENOGRAPHER: In the what? In the
4 what hospital?

5 **THE WITNESS: In Texas.**

6 THE STENOGRAPHER: You said in Louis?

7 **A Oh. I was selected to be a physician at the Louis**
8 **and -- Louis & Peach Heart Hospital, which is a --**
9 **kind of a select area in the Christus Trinity**
10 **Mother Frances Hospital.**

11 And in that role, my job primarily
12 focused on cardiovascular and pulmonary health.

13 It was a pulmonary ICU IMC, CVICU, CV -- and
14 transplant center -- or valve center. Sorry.

15 Q Are you talking about your job in Texas?

16 **A Correct, yes. So when I transferred here and when**
17 **I came here, it reverted back to a general, like a**
18 **regular hospitalist physician role.**

19 Q How long did you hold the position, as you say, of
20 a regular hospitalist at St. Elizabeth?

21 **A I stayed here until, I have to think now, April or**
22 **March of 2022. Yes.**

23 Q And was -- until you left -- I'm assuming you left
24 in April, March or April of 2022?

25 **A Yes. I transferred to another Ascension facility,**

1 'cause I actually was in the process of moving to
2 Chicago at that time.

3 Q In the time period of August of 2020 when you came
4 to St. Elizabeth through March or April of 2022
5 when you transferred to another Ascension
6 hospital, was your position that of a regular
7 hospitalist?

8 A Yes, an inpatient hospitalist, correct.

9 Q Okay. And did you work in the ICU at St.
10 Elizabeth like you did at the Texas hospital?

11 A Yes.

12 Q Okay. Did St. Elizabeth have -- strike that.
13 When a generalist physician at St.
14 Elizabeth is working in the ICU, is there a
15 similar requirement that a critical care physician
16 be collaborating on that case with that general
17 hospitalist?

18 A Yes.

19 Q Okay. And you mentioned earlier that you did
20 treat Grace at St. Elizabeth, correct?

21 A Yes.

22 Q Okay. Was Grace in the ICU at St. Elizabeth?

23 A Yes.

24 Q Okay. Did you have an intensive care -- or sorry,
25 a critical care physician collaborating with you

1 on Grace's case?

2 **A Yes.**

3 Q Okay. Who was that physician?

4 **A They rotated, but the one that I was interacting**
5 **was Dr. Gandev. He was on the day prior and on**
6 **the day -- on October 12th and October 13th is**
7 **when he was working.**

8 Q Is it correct that you only provided care to Grace
9 on October 12th and October 13th?

10 **A Yes.**

11 Q So, is it correct that Dr. Gandev would have been
12 that consulting critical care physician the entire
13 time you were treating Grace?

14 **A Correct.**

15 Q You mentioned earlier that in March or April of
16 2022 you transferred to another Ascension
17 hospital; is that correct?

18 **A Yes.**

19 Q And was that hospital in Chicago?

20 **A Yes.**

21 Q What hospital was that?

22 **A That's St. Mary's -- St. Mary's and Elizabeth**
23 **Medical Center in Chicago.**

24 Q Okay. When you first took that transfer, what was
25 your position at that Chicago hospital?

1 **A The same role, hospitalist physician.**

2 Q Do you work at that hospital now?

3 **A I do.**

4 Q Do you still have the same role that you did when
5 you first transferred there?

6 **A No.**

7 Q Okay. What role do you have now?

8 **A I'm the medical director of the hospitalist
9 division.**

10 Q I believe you said hospitalists division?

11 **A Yeah, the medicine department, essentially. I'd
12 note that role starts June 1st.**

13 Q Of?

14 **A Of this year.**

15 Q Oh. It will start --

16 **A It will start June 1st, yes, but my roles and
17 responsibilities have already begun.**

18 Q Would you consider that a promotion?

19 **A Yes.**

20 Q Okay. Before you got this promotion, was your job
21 the same as it was when you first arrived at that
22 Chicago hospital?

23 **A Yes.**

24 Q Okay. We're going to take a look at some records,
25 I think the notes that you referenced that you had

1 reviewed.

2 **A Sure.**

3 MR. EDMINISTER: 60?

4 MR. PFLEIDERER: Just as soon as I get
5 the right folder.

6 (Discussion off the record.)

7 BY MR. PFLEIDERER:

8 Q Mr. Shokar, the -- I'm going to hand -- sorry.
9 Dr. Shokar.

10 **A Thanks.**

11 Q Dr. Shokar, I just handed you what's been marked
12 as Exhibit 70. There at the top it says Progress
13 and Staffing Note.

14 Do you see that?

15 **A Yes.**

16 Q Okay. This note purports to be authored by you.

17 Do you recognize this note?

18 **A I do.**

19 Q Okay. Is this one of the notes that you reviewed
20 in preparation for this deposition?

21 **A Yes.**

22 Q Okay. Did you author this note?

23 **A I did.**

24 Q Okay. Does this note appear to be a true and
25 accurate representation of that note as you

1 authored it? You can take a second to read it if
2 you want.

3 MR. FRANCKOWIAK: Counsel, could you
4 identify the Bates stamp on this document?

5 MR. PFLEIDERER: This is Ascension
6 00041.

7 **A This looks the same.**

8 BY MR. PFLEIDERER:

9 Q The date of service on this note is October 12th,
10 2021.

11 Do the notes in this document
12 relate to Grace's condition on October 12th of
13 2021?

14 **A They do.**

15 Q Okay. And then on the second page there, the time
16 of dictation of this note appears to be 10:18 a.m.

17 Do the notes in this document
18 relate to Grace's condition on or about that time
19 on October 12th, 2021?

20 **A They reflect the time prior to, you know, that
21 morning up until that time.**

22 Q Because this would have to be observed before you
23 dictated it?

24 **A Correct.**

25 Q So we can assume that these observations would

1 have been made shortly before you dictated this
2 note?

3 **A Correct.**

4 Q Okay. And do you attempt to dictate notes soon
5 after you make these observations?

6 **A I try to.**

7 Q Okay.

8 **A Sometimes you see a few patients in a row and then
9 dictate them all in a batch. It just depends on
10 the day.**

11 Q So you may dictate notes after you've seen a few
12 patients and then do them all at once?

13 **A Correct.**

14 Q But you would try to get the notes dictated by,
15 let's say, the end of the shift?

16 **A Yes.**

17 Q Okay. Besides the time of dictation, is there any
18 way to tell when these notes were -- or I guess
19 the observations that led to these notes were
20 made?

21 **A Not on the document. I mean, they would be --
22 have been observed between, you know, 7:00 and
23 10:00, I guess, of when this document was
24 dictated, but they are a reflection of my morning
25 assessment of Grace.**

1 Q Okay. At the top -- I'm looking at the Subjective
2 there at the top, you stated that Grace was
3 comfortable and calm.

4 Do you see that?

5 **A Yes.**

6 Q Is it your recollection that Grace was comfortable
7 and calm on October 12th shortly before
8 10:18 a.m.?

9 **A Yes.**

10 Q Okay.

11 **A At the time of evaluation.**

12 Q Of course. And continuing, you state that Grace
13 was, quote, "somewhat cooperative."

14 Do you see that?

15 **A I do.**

16 Q Is it your recollection that Grace was somewhat
17 cooperative that morning?

18 **A I do. When I -- I will clarify cooperative.**

19 Cooperative is usually, you know,
20 in -- in my examination, history taking
21 examination, when I see a patient, if they're able
22 to, you know, breathe in, breathe out when I ask
23 them to participate in the examination. In this
24 instance she was not cooperative in regards to
25 talking to me because she was relatively nonverbal

1 to myself. But, you know, I could say that she
2 was, you know, trying.

3 Q Trying to talk?

4 A Well, she was trying to interact, at least, you
5 know, as best as she could that day.

6 Q Okay. Did you then attempt to talk with Grace?

7 A Of course, yeah.

8 Q Okay. Did Grace have a BiPAP mask on at that
9 time?

10 A She did.

11 Q Did you remove the BiPAP mask when you attempt to
12 talk with her?

13 A No.

14 Q Does the BiPAP mask make it difficult for a person
15 to talk in your experience?

16 A It does.

17 Q So when I see the phrase "somewhat cooperative," I
18 interpret that as also somewhat not cooperative;
19 is that fair?

20 A It was my best assessment of her ability to
21 cooperate. I wouldn't say that she was
22 belligerently not cooperative or anything like
23 that. It was just my assessment of what her
24 capabilities were at that time.

25 Q Okay. So if a BiPAP mask makes it difficult to

1 speak and her lack of cooperation, as you say, was
2 her failure to speak verbally with you, what is
3 the value of the observation of somewhat
4 cooperative?

5 Does that question make sense to
6 you?

7 **A Not really.**

8 **Q** Okay. You mentioned -- or you said earlier that a
9 BiPAP mask makes it difficult to speak, correct?

10 **A** It makes it difficult to -- there's two elements
11 of speech; one is the person trying to speak and
12 one understanding what the person is saying, or
13 hearing, basically saying what you can hear.

14 On one element, with a BiPAP mask
15 on, you have air pushing into your mouth. And so,
16 you know, it depends on if someone's able to, you
17 know, talk loud enough over the pressure that's
18 being supplied through the mask.

19 And then the other aspect is, you
20 know, is it loud enough for the person to hear,
21 and so you generally have to lean in and try to,
22 like, you know, hear them. When I put "somewhat
23 cooperative" when you're asking her questions, the
24 effort to actually communicate was not there, but
25 the effort to breathe in and breathe out and do

1 the physical aspects of an examination were. And
2 that's more reflective of what somewhat
3 cooperative would mean.

4 Q Understand. Thank you.

5 Are there any other aspects of
6 Grace's behavior that you can recall that were not
7 cooperative as you meant it here in this note?

8 A Not that I directly observed at the time of
9 evaluation.

10 Q The second-to-last sentence at the end of the
11 Subjective says "no concerns overnight."

12 Do you see that?

13 A Um-hmm.

14 MR. GUSE: Is that a yes? You have to
15 say yes.

16 A Oh, I'm sorry. Yes.

17 BY MR. PFLEIDERER:

18 Q Thank you. That was a favor of your attorney to
19 inform me.

20 MR. GUSE: Keep that in mind.

21 MR. PFLEIDERER: Yeah, I will. Thanks.

22 BY MR. PFLEIDERER:

23 Q What do you mean by -- I know this sounds like a
24 silly question, but what do you mean by "no
25 concerns overnight"? I mean, clearly Grace is in

1 the hospital, there are concerns.

2 A Um-hmm.

3 Q When you say "no concerns overnight," what do you
4 mean by that statement?

5 A This was my first day seeing Grace. The
6 information that I gather is, you know, to kind of
7 find what her daily status is, incorporates the
8 information that I'm able to ascertain in the
9 interview, the information that I'm told after
10 talking with nursing, and the information from
11 family in the room.

12 Q Sure.

13 A And at the time of my initial evaluation on -- the
14 first time I saw her, there were no reports
15 directly given to me of issues that happened
16 overnight. The family at bedside did not report
17 any concerns overnight. And I didn't -- obviously
18 couldn't, you know, get a direct report from
19 Grace.

20 So when I write a statement like
21 "no concerns overnight," it's in reflection of
22 were there, you know, severe, acute medical
23 problems or things that need to be -- that need to
24 be -- well, I will put it into the subjective
25 generally to say something happened, and then in

1 **that way I can set up my note to address that**
2 **objectively and then in an assessment and plan.**

3 Q Okay. I'm going to switch down there to the
4 objective.

5 **A Sure.**

6 Q There's a temperature of 99.9.

7 Do you see that?

8 **A I do.**

9 Q Was this one of the vitals that you reviewed in
10 preparation for this deposition today?

11 **A Yes.**

12 Q Okay. Do you recall whether Grace's temperature
13 was 99.9 degrees?

14 MR. GUSE: Objection. The document
15 speaks for itself.

16 BY MR. PFLEIDERER:

17 Q I'm asking if he agrees with the document.

18 **A Say -- you're asking me if I agree with the**
19 **document?**

20 Q Yes.

21 **A The temperature that's recorded on the document is**
22 **a temperature that has been taken not by myself**
23 **but by nursing and listed in the computer at the**
24 **time of my note.**

25 Q You wouldn't have any reason to dispute that

1 Grace's temperature at the time it was recorded
2 was 99.9 degrees, correct?

3 **A Correct.**

4 **Q** Is a temperature of 99.9 degrees, do you consider
5 that above normal?

6 **A A fever is 100.4. So technically, it's in the**
7 **normal range. But it is -- I mean, I want**
8 **everyone at 98 or so. I mean --**

9 **Q** You said it might be approaching a fever?

10 **A Might be approaching, but it's technically not a**
11 **true fever.**

12 **Q** Technically not.

13 In this sort of situation at this
14 time you wrote this note, does that temperature,
15 does that give you any concerns that tell you
16 anything about the condition that Grace was in,
17 and if so, what?

18 **A Not by itself.**

19 **Q** Okay. In conjunction with what would it give you
20 a concern?

21 **A The temperature of 99.9 in conjunction with an**
22 **inflammatory response may lead me to the suspicion**
23 **that, you know, something is going on and it needs**
24 **to be monitored, essentially. Because an**
25 **independent reading by itself is not reflective of**

1 anything unless it's persistent or reaches to a
2 true level, such as 100.4.

3 So it could reflect any type of
4 stress in her body, anything, which she obviously
5 was under duress because she was requiring BiPAP.

6 Q And a fever in conjunction with an inflammatory
7 response, would that indicate you a possible --
8 indicate to you a possible bacterial or viral
9 infection?

10 A It can.

11 Q Okay. At any time during your treatment of Grace
12 did you ever consider whether she had a bacterial
13 infection in her lungs?

14 A It's something that's always in the back of my
15 mind as a possibility. Given the fact that she
16 was in a frail state, in respiratory -- you know,
17 with a respiratory ailment, there's always a
18 possibility of a bacterial superinfection, an
19 opportunistic infection that would, you know,
20 become problematic. So it's always something that
21 is considered.

22 Q Would you particularly consider bacterial
23 infection in the case where steroids were also
24 being prescribed?

25 A Steroids could lower the immune system to allow

1 for the opportunistic infection to cause problems,
2 yeah.

3 Q And being that you considered bacterial infection
4 or you said that it's always in your mind -- did
5 I -- is that right, it's always in your mind?

6 A It's always in the back of your mind on a
7 differential when you're presented with data that
8 supports an infectious, you know, process.

9 Q Okay. So what, if anything, did you do to
10 evaluate whether there was a potential bacterial
11 infection in Grace?

12 A So when you're evaluating somebody for an
13 infectious process, you also have to evaluate them
14 for their differentials. And, you know, in this
15 particular case we knew someone who had, you know,
16 a viral infection, and there was somebody who --
17 this was somebody who had a viral infection with
18 inflammatory response, which was known from -- you
19 know.

20 And when you look at probabilities
21 of different diagnosis, differential diagnosis
22 that would supersede, that would be much higher
23 than, you know, a bacterial infection, you
24 correlate your evidence with things like
25 laboratory results, imaging, such as the chest

1 x-ray, which I had reviewed, collaboration with
2 your physicians, if needed, and then you basically
3 make a clinical assessment on the likelihood and
4 the probability of, you know, the diagnosis and if
5 that's actually happening.

6 Q You said that at this point it was known that the
7 infection was viral.

8 How was it known to you?

9 A The patient had been diagnosed with COVID.

10 Q Okay.

11 A Which is a viral infection.

12 Q Are you relying on anything else besides that
13 diagnosis to determine that this infection was
14 viral as opposed to bacterial?

15 A It's -- it's -- again, when you're looking at a
16 differential diagnosis, you're looking at
17 probabilities. And so if you have a known -- of a
18 viral infection and, you know, a late phase COVID
19 inflammatory response, that -- and then you have a
20 syndrome, such as inflammation or whatnot or
21 fever, you're going to place that with the highest
22 likelihood and then move downwards.

23 And in this situation, for
24 instance, you know, an inflammatory response from
25 a complication or a light phase of COVID, which is

1 what had been the running diagnosis in the
2 hospital up until I took care of Grace, and what
3 I, on my review, it also seemed like would be the
4 most likely diagnosis in an event of an
5 inflammatory -- you know, an inflammatory cas --
6 inflammatory markers or infectious markers being
7 elevated.

8 And it's my -- part of the
9 difficulties of being a clinician is to use all
10 the data in your clinical impression to weight
11 what is most likely and what is less likely,
12 because the intervention of such in its own right
13 has its risks and rewards as well.

14 So in this particular case, my
15 impression was an ongoing inflammatory response
16 from my -- a post-viral syndrome from COVID.

17 Q Did you ever evaluate Grace's white cell count or
18 neutrophil count?

19 A Yes.

20 Q And what were your interpretations of those? Are
21 you looking there at that note, laboratory data,
22 WBC 10.2.

23 A Yes.

24 Q Is that where you're looking?

25 A Yes.

1 Q What is a WBC of 10.2? What impression does that
2 give you?

3 A It gives me an impression that there is a mild
4 elevation possibly of her white blood cell count,
5 in its own right is not something that I will jump
6 on, you know, to make any conclusion of.

7 Generally, if you have an
8 infectious issue --

9 Q When you say infectious --

10 A Um-hmm.

11 Q -- are you referring to bacterial infection or
12 viral?

13 A Bacterial. My apologies. When you're dealing
14 with a new infection, bacterial infection, and
15 even possibly a new viral infection, you would see
16 a jump up or spike up in your white blood cell
17 count, so you'd actually trend that and you'd see
18 it quite elevated or heading that way.

19 When you -- and again, that's one
20 piece of your -- your tools and your evidence to
21 try to figure out the overall picture. So in this
22 case being 10.2, not significantly elevated,
23 something to be monitored, and white blood cell
24 counts also go up for other reasons besides
25 infections.

1 Q Would you agree that broad-spectrum antibiotics
2 are generally well tolerated in clinical patients?

3 MR. GUSE: Objection. Incomplete
4 hypothetical.

5 BY MR. PFLEIDERER:

6 Q You can answer.

7 MR. GUSE: Are you talking about
8 bacterial infections, viral infections?

9 MR. PFLEIDERER: Well, antibiotics are
10 only being used for bacterial, so --

11 THE STENOGRAPHER: I'm sorry. I didn't
12 hear you.

13 MR. PFLEIDERER: I'm sorry. I just said
14 antibiotics are really only used for bacterial
15 infections, so those are the ones I'm referring
16 to. Antibiotics that treat bacterial infections.

17 **A Can you repeat the question?**

18 BY MR. PFLEIDERER:

19 Q Sure. Is it your opinion that broad-spectrum
20 antibiotics are generally well tolerated by
21 clinical patients?

22 MR. GUSE: Again, I'm going to object to
23 the question as being an incomplete and improper
24 hypothetical. You're talking -- if you can answer
25 the question, go ahead, but --

1 **A** **Sure. Depends on the patient. In general -- what**
2 **does "in general" mean? Sorry. Can you clarify**
3 **that? What patient population are we talking**
4 **about?**

5 BY MR. PFLEIDERER:

6 **Q** **I would say the average person admitted into the**
7 **clinical setting.**

8 **A** **Like a -- what -- so I'll help you out here.**

9 **Q** **Sure.**

10 **A** **If a -- patients admitted generally have an acuity**
11 **attached to them. The general amount of patients**
12 **that come into the hospital are not of a severe**
13 **acuity, right, they're of a regular acuity. So in**
14 **general, for a regular acuity or a low-acuity**
15 **patient, they are well tolerated.**

16 **Q** **Let me ask you a better question.**

17 **A** **Um-hmm**

18 **Q** **In Grace's case, what were some of the risks of**
19 **giving her antibiotics?**

20 MR. GUSE: Objection. Assumes facts not
21 in evidence, i.e. that there's a bacterial
22 infection.

23 MR. PFLEIDERER: It doesn't assume that,
24 but you can answer.

25 **A** **Okay. Giving Grace antibiotics -- when I give**

1 anybody antibiotics, first of all, you have to
2 weigh the risks and benefits of giving that
3 intervention. Okay.

4 So if you feel that there's no
5 benefit for giving the medication, then the risks
6 outweigh the benefits, and therefore, immediately
7 there's no -- we don't -- I don't move along to
8 are there going to be side effects of medicine I'm
9 never going to give. Right?

10 BY MR. PFLEIDERER:

11 Q So at this time are you inferring that at this
12 point you felt that there were zero possible
13 benefits of giving antibiotics to Grace?

14 A My clinical impression did not support the use of
15 broad-spectrum antibiotics as an intervention
16 because I had not formulated a diagnosis. I
17 didn't have enough evidence to formulate a
18 diagnosis of a bacterial infection that would
19 support the use of an antibiotic.

20 Q Was it your opinion at this time that you had
21 collected enough evidence to formulate a diagnosis
22 that she did not have bacterial pneumonia? In
23 other words, had you ruled out bacterial
24 pneumonia?

25 A Bacterial pneumonia is always in the back of my

1 mind as a possibility for a superinfection, as I
2 previously said. But it's something that, again,
3 we weigh as a differential to determine what the
4 probability of a bacterial infection is and if
5 that probability is high enough in your clinical
6 impression to supersede the current diagnosis or
7 other alternative explanation that's more
8 probable.

9 Q And at what point would that probability be high
10 enough?

11 A If Grace's white blood cell count, for instance,
12 had spiked up and she was starting to produce, you
13 know, cough with sputum, green phlegm, other signs
14 of a pneumonia, chest pain, you know, blood in
15 sputum, those kind of things, clinically, you
16 know, you suspect maybe there's an alternate
17 infection going on. Radiographically, you look at
18 the type of infections and pneumonias that occur,
19 and radiographically the most common pneumonia,
20 for instance, would be a lobar pneumonia, you
21 know, and you'd see a particular pattern on
22 imaging. Less commonly are atypical pneumonias.
23 You know, you look for all these kind of patterns
24 and things that you can recognize that will
25 support the consideration of a pneumonia.

1 Q When you were treating Grace -- thank you for
2 that.

3 When you were treating Grace, did
4 you ever become aware that Grace had a home CPAP
5 machine?

6 A Yes.

7 Q Okay. With people who -- strike that.

8 Did the fact that she had a home
9 CPAP machine ever cause you to consider that she
10 had possible Legionnaires' disease? And why or
11 why not?

12 A That would have been a clinical impression that
13 would have been considered on admission, on
14 initial presentation, as an uncommon pneumonia,
15 you know. And usually it will, again, have a
16 particular presentation that the, you know,
17 initial clinicians would, you know, if their
18 clinical impression was strong enough would test
19 for and treat. Just because you have a CPAP
20 machine doesn't mean you get Legionella, though.
21 I mean, it's not -- it is a -- it is a possibility
22 but it's not -- it's not a probability.

23 Q What is the presentation of that disease?

24 A You can have pneumonia with Legionnaires, but you
25 also have some GI issues as well usually,

1 associated with things like air-conditioning and
2 other things that give off moisture.

3 Q I'm going to go back to the note here.

4 A Sure.

5 Q Under Imaging, you state that chest x-ray from
6 October 11th, 2021 revealing worsening pulmonary
7 opacities, bilateral, concerning for pneumonia or
8 edema. PICC in place.

9 Do you see that?

10 A Um-hmm. Yes. Sorry.

11 Q Thank you. It's a great witness that corrects
12 himself on that.

13 First, can you describe what you
14 mean by worsening opacities.

15 A The chest x-ray was the day prior to the
16 evaluation that I did on Grace on the 12th; it was
17 on the 11th. And it is a -- generally a
18 reflection of when the radiologist reviews it from
19 prior, or the clinician reviews it from prior, we
20 can see a pattern to suggest if there's stability,
21 improvement or deterioration.

22 So worsening pulmonary opacities in
23 this case indicates that the presentation on the
24 radiographic images looked worse than the prior,
25 yeah.

1 Q And is that an interpretation that you're making,
2 or are you getting that interpretation from
3 somebody else in regard to what you wrote in this
4 note?

5 A Sure. My -- my standard practice is I'll look at
6 the images myself, and then I'll read the
7 radiology report and see if we're aligned in that
8 regard. But the radiologist generally has much
9 more experience in reading radiographs, obviously,
10 x-rays and whatnot, and so I will always rely on
11 their interpretation over mine.

12 Q So you would read it yourself first so that you
13 don't bias your opinion?

14 A Correct. I'll look at the images myself, yes.

15 Q And then you'll review the radiology report?

16 A And then I'll -- correct, and then I'll see
17 what -- if it matches.

18 Q And if it didn't match, what would you do then?

19 A Usually I'll go up and talk with the radiologist
20 or the pulmonary critical care doctor and we'll
21 review the images on a PACS system monitor.

22 Q Um-hmm, try to work it out?

23 A And I'll -- I mean, that's also for my education
24 as well, and radiology.

25 Q Sure. And you see there where it also says

1 "concerning for edema"?

2 A Um-hmm. Yes.

3 Q Thank you.

4 What did you do, if anything, to
5 address this possible concern for edema?

6 A The -- the problem with x-rays is, when you have a
7 read-out, they usually will put all possibilities
8 depending on the type of radiologist that's
9 reporting. Okay? And many times when you see
10 patchy infiltrates, both sides of the lungs on an
11 x-ray, it could reflect differential diagnosis, as
12 I mentioned before. And then you have to match it
13 with your clinical impression as well and what
14 you're auscultating by ear with a stethoscope.

15 And so a lot of the times we run
16 into a problem in which an x-ray will say
17 pulmonary infiltrates, pneumonia, or a pulmonary
18 vascular congestion or edema, and we kind of have
19 to work out the impression of it.

20 The problem with -- in Grace's
21 situation with the edema aspect of things, I
22 didn't -- I didn't hear crack -- pulmonary rales,
23 which is the general term for fluid in the lungs.

24 Q Is that crackling? Is that what you were about to
25 say?

1 **A** **Crackling, yes. And giving her the intervention,**
2 **which would have been a water -- a diuretic like**
3 **Lasix, would have dropped her blood pressure**
4 **further. And she actually wasn't having much**
5 **intake. You know, so I didn't -- again, you weigh**
6 **in your clinical analysis of what's safe to do,**
7 **you know, and so I don't think -- that's not**
8 **something that I was going to intervene on if it**
9 **wasn't matching with what my clinical impression**
10 **was.**

11 **Q** **So, is it fair to say that you did not order Lasix**
12 **because you were concerned about a drop in blood**
13 **pressure, or is there another reason?**

14 **A** **I would not have ordered Lasix if I believed that**
15 **she was overloaded with fluid, which I did not**
16 **believe.**

17 **Q** **Got it. Looking at Assessment --**

18 **A** **Sure.**

19 **Q** **-- No. 3 says "malnutrition due to BiPAP**
20 **requirement."**

21 Do you see that?

22 **A** **I do.**

23 **Q** **As you sit here today, do you agree that at the**
24 **time you did this note Grace was malnourished due**
25 **to her BiPAP requirements?**

1 A I do.

2 Q Besides her BiPAP requirements, was there anything
3 that indicated to you that Grace was malnourished,
4 either a lab or a vital or some kind of visual
5 appearance, or anything else?

6 A Mainly historical evidence that she was -- her
7 intake was not great and her hospital stay was
8 prolonged to the degree in which most people who
9 enter the hospital in a critical care environment
10 enter a katabolic state, lose protein mass, and
11 become malnourished. And her respiratory drive
12 was significantly elevated, which increases your
13 metabolic requirement by about 25 percent, up to
14 there, let's say.

15 Q Could you say that one sentence again, please.

16 A When you have respiratory distress and you're
17 breathing at 40 times a minute, your energy needs
18 go up.

19 Q Sure.

20 A And -- in which case you need nutrition to support
21 your body and your cells. And if you don't, at
22 some point they collapse.

23 Q So you mentioned increased metabolic state.

24 When you say malnourished due to
25 her BiPAP requirements, are you saying that

1 because the BiPAP is on her face, she can't eat?
2 Is that what has caused the malnourishment, or is
3 there something about the BiPAP requirements
4 except for the increased metabolic rate that is
5 causing this malnourishment? That was a really
6 long question. I'll break it up if you want.

7 MR. GUSE: Yeah, I'm going to object to
8 the form the question as being vague.

9 MR. PFLEIDERER: That's fair. I'll ask
10 another question.

11 BY MR. PFLEIDERER:

12 Q You just mentioned that people in respiratory
13 distress have an increased metabolic rate,
14 correct?

15 **A Correct.**

16 Q Do people on BiPAP have an increased metabolic
17 rate just by something going on with their BiPAP,
18 or is it the fact that they're in respiratory
19 distress and on the BiPAP? Does that make sense?

20 **A Yes, the --**

21 MR. GUSE: I just want to be clear.
22 You're talking about in general, not in Grace's
23 case?

24 BY MR. PFLEIDERER:

25 Q Yes.

1 **A** **In general. The underlying reason for the**
2 **requirement of BiPAP would have led to the**
3 **increased metabolic needs.**

4 **Q** That was my question.

5 Okay. Looking at plan -- looking
6 at No. 3 under Plan. Are you with me?

7 **A** **Yes.**

8 **Q** Okay. You say requiring Precedex at 0.6.

9 Do you see that?

10 **A** **Yes.**

11 **Q** Okay. When you say at the 0.6, is that a rate
12 that you're giving?

13 **A** **0.6 is, as I wrote it, is the dose that she was**
14 **on, you know, per hour.**

15 **Q** It's a dose per hour?

16 **A** **I believe, yes.**

17 **Q** So that is a rate?

18 **A** **Rate, yeah.**

19 **Q** Yeah. And that is 0.6 what per hour?

20 **A** **Milligrams.**

21 **Q** Okay. And why, at this time, if you recall, did
22 Grace require Precedex at a rate of 0.6?

23 **A** **The -- when you're in an ICU setting with a BiPAP**
24 **on with a -- at this point it was a moderate**
25 **amount of pressure. She was at 15 over 12 in an**

1 unfamiliar environment, undergoing stress, you
2 know, you can get agitation, anxiety and
3 agitation. And one of the modalities that we can
4 use to help calm you down is the use of Precedex.

5 Generally used if you are
6 exhibiting behaviors that would impair things like
7 keeping your BiPAP on or your PICC line in. You
8 know, so that -- and the other reason you would
9 use it is to control a respiratory rate that's
10 already elevated to prevent it from going, you
11 know, higher and then causing hypoxia, further
12 hypoxia.

13 Q You just mentioned that Precedex is one of the
14 modalities to calm someone down. Is that sort of
15 the general purpose for this Precedex is to calm
16 Grace down specifically?

17 A Yes.

18 Q Okay. And what other modalities besides Precedex
19 would have been available in Grace's case to calm
20 her down?

21 A There's only a few. One would be a
22 benzodiazepine. She was also on a benzodiazepine
23 to help in that situation as well.

24 Q Any modalities that are not pharmaceutical?

25 A Behavioral modification, you know, kind of

1 redirection, sun therapy, keeping the blinds open
2 during the day, closed at night, kind of
3 redirecting to prevent delirium. Family, you
4 know, are usually huge assets to kind of help in
5 that situation as well. Sometimes those are a
6 little bit challenging, particularly in the COVID
7 situations when you're in an isolation room.

8 Q You said behavioral modification. What do you
9 mean by that?

10 A Let me return to redirection, behavioral
11 redirection; trying to kind of use a humanistic
12 approach to kind of calm someone down before
13 intervening with medications.

14 Q During your treatment of Grace on October the
15 12th, did you witness anyone attempt any
16 redirection or behavioral modification with Grace?

17 MR. GUSE: I'm going to object. I think
18 that invades the Alt privilege, 'cause it's
19 suggesting potential criticism of another
20 caregiver, and I'm going to instruct you not to
21 answer the question.

22 MR. PFLEIDERER: I'm just asking about
23 what he saw. That's it. He's a fact witness.

24 MR. GUSE: To the extent that -- I will
25 allow it to the extent of his observations.

1 Nothing further.

2 BY MR. PFLEIDERER:

3 Q That was the question.

4 Did you witness it?

5 A Let me think back. I think her family -- Jessica
6 was in the room. And I -- I think -- I mean,
7 obviously she was an asset to try to help, you
8 know, calm Grace down. I didn't directly observe
9 her doing so at the time, because during this
10 assessment she was calm, so I didn't -- I mean,
11 there was no need for a behavioral approach
12 because she was alright at that time. But there
13 was family that was able to assist in that event.

14 Q Is behavioral modification something that family
15 would participate in, or would medical providers
16 also participate in behavioral modification?

17 A Behavioral redirection can be given by -- we
18 personally would appreciate any and all personnel
19 that can assist. Often there's a staffing
20 limitation to do so. It's -- it's not always -- I
21 mean, honestly, it's not that successful a lot of
22 the times. Yeah, it's -- it's an option. It's a
23 good option.

24 Q Sure. Did you witness any providers attempting
25 behavioral, as you say, redirection with Grace on

1 October the 12th?

2 **A No.**

3 Q Did you -- strike that.

4 Do you have any knowledge from any
5 source about any medical provider attempting
6 behavioral redirection with Grace on October 12th?

7 **A Hm. I don't have knowledge of any of that.**

8 Q You mentioned that often behavioral modification
9 or redirection -- do you have a preference which
10 one I say?

11 **A Redirection is probably better. Modification
12 ensues that we're trying to change somebody.**

13 Q Sure. You mentioned earlier that behavioral
14 redirection is often difficult due to staffing
15 requirements that that entails.

16 Were there any issues with staffing
17 on October 12th that would have prevented
18 behavioral redirection from occurring from medical
19 providers?

20 MR. FRANCKOWIAK: Objection.
21 Foundation.

22 MR. GUSE: Join. Outside the scope of
23 the witness' testimony.

24 MR. BIRNBAUM: I'll join, too. And
25 John, if we can just agree that an objection by

1 one is an objection by all.

2 MR. PFLEIDERER: Yeah, that's fine.

3 You can answer the question.

4 MR. GUSE: Subject to the objections,
5 you can answer, Doctor.

6 **A Oh, okay. Sorry. Can you repeat the question**
7 **then?**

8 MR. PFLEIDERER: Would you read it back,
9 please.

10 (Question read.)

11 **A Not that I'm aware.**

12 BY MR. PFLEIDERER:

13 Q What about on the 13th?

14 MR. FRANCKOWIAK: Same objections.

15 MR. GUSE: Same objections and also
16 vague as to talking about nursing, CNAs?

17 BY MR. PFLEIDERER:

18 Q I said medical providers, any.

19 **A As I say, medical providers, generally we don't**
20 **provide the behavioral redirection unless we're in**
21 **the room to do it. And we rely on our nursing**
22 **staff, CNAs, et cetera, to provide that and, of**
23 **course, family members as well.**

24 Q But your answer to the question, were there
25 staffing issues that prohibited the behavioral

1 redirection on October 13th, your answer, like the
2 12th, would be no?

3 MR. GUSE: I'm just going to object. It
4 misstates his testimony and you changed the
5 question.

6 **A Can you clarify if you meant physician staffing**
7 **or --**

8 BY MR. PFLEIDERER:

9 Q Strike the question. I'll ask it again.

10 I mean any medical provider, staff,
11 whether it be physician, RN, CNA, anything.

12 **A So incorporate everybody.**

13 Q And I understand the nurses are typically the ones
14 that are going to be doing this.

15 **A I think there was adequate staffing.**

16 Q Okay. I'm going back to the note. We're still on
17 No. 3 of Plan.

18 Are you back with me?

19 **A Um-hmm.**

20 Q You state, "She is hyperventilating possibly from
21 anxiety, which is going to impair her
22 oxygenation." I'm sorry, Dr. Shokar. We're going
23 to have to go back.

24 You mentioned sun therapy as a
25 possible modality that could have been used to

1 calm Grace down.

2 Do you remember that?

3 **A Yes.**

4 **Q** Okay. Do you know if at any time during your care
5 sun therapy was effectuated in Grace's room or
6 with Grace?

7 **A** It's a -- when I say sun therapy, what I was
8 alluding to was the -- keeping the blinds open so
9 that any direct sunlight can enter the room to
10 keep someone orientated and less agitated. It's
11 an effective means in people who have delirium in
12 the hospital, for instance. And I'm not aware if
13 that was something that was employed. I have no
14 idea.

15 **Q** Okay. All right. We're going to go back down to
16 No. 3 of Plan.

17 **A** **Sure, sure.**

18 **Q** All right. So like I just said, but I'll repeat
19 for clarity, you state, "She is hyperventilating
20 possibly from anxiety, which is going to impair
21 her oxygenation."

22 Do you see that?

23 **A** **Yes.**

24 **Q** Now, you used the words "going to impair."

25 Does this mean that at the time you

1 wrote this note you did not think that
2 hyperventilation was impairing Grace's oxygen?

3 **A Correct.**

4 **Q** Okay. Does this mean that you thought it would in
5 the future?

6 **A It means that if you're hyperventilating, you**
7 **could impair your oxygenation if you are not able**
8 **to support the respiratory rate.**

9 **Q** When you use the term "hyperventilating," is there
10 a particular respiratory rate that you would
11 consider the threshold for hyperventilating?

12 **A There is a threshold, but it is dependent on a**
13 **pattern and also the patient's presentation.**
14 **Generally, you can say that someone whose**
15 **respiratory rate is over 20 is hyperventilating if**
16 **you, you know -- depending on if it's -- if it's a**
17 **low acuity patient with some, you know,**
18 **consideration that the respiratory rate is**
19 **normally around 10 or 12 or so, and now all of a**
20 **sudden it's up. So now they're hyperventilating,**
21 **but you have to then understand what the context**
22 **or the reason for that hyperventilation is.**

23 **Q** Is hyperventilation more of a statement about
24 respiratory rate or about blood gas?

25 **A About respiratory rate.**

1 Q Okay. So it would be fair to say that a high
2 respiratory rate and hyperventilation, those are
3 interchangeable terms?

4 **A Yes.**

5 Q You state that this hyperventilation is possibly
6 from anxiety.

7 Do you see that?

8 **A Yes.**

9 Q You say possibly here.

10 What, if anything, did you do to
11 investigate whether or not the hyperventilation
12 was being caused by anxiety?

13 **A Can you clarify?**

14 Q Sure. You say possibly like you're not sure.
15 Could be. Right?

16 **A Um-hmm, um-hmm.**

17 Q What, if anything, did you do to investigate
18 whether the hyperventilation was in fact being
19 caused by anxiety?

20 **A Any time a clinical problem presents itself, I**
21 **create a differential diagnosis, and each one has**
22 **a weighted possibility. Anxiety being on the**
23 **differential diagnosis for hyperventilation in**
24 **this situation; the other being hypoxia from her**
25 **underlying illness, which would then stimulate**

1 hyperventilation to keep her as oxygenated as
2 possible.

3 The problem that arises, if you --
4 if your body raises your respiratory rate to a
5 level that is unsustainable for oxygenation, then
6 you start heading the other way again. So it's an
7 appropriate -- hyperventilation is an appropriate
8 response to an underlying condition. When you
9 feel dyspneic --

10 Q What was that word?

11 A -- or when you feel like you have air hunger, when
12 you feel short of breath, or if you actually are
13 hypoxic when you have a low oxygenation, and
14 therefore, psychologically, if you feel short of
15 breath or in a panic attack, you're going to
16 hyperventilate. And physiologically, if you
17 actually are hypoxic, you're going to
18 hyperventilate. So they're both on the
19 differential in the situation.

20 Q At the time you made the observations that led to
21 this note, did you observe that Grace was
22 agitated?

23 A At the time of my evaluation, she did not seem
24 agitated.

25 Q And how do you distinguish from anxious and

1 agitated in this kind of clinical setting here?

2 **A Agitation in -- there's a lot of overlap, but**
3 **anxious is more of a psychological presentation**
4 **that causes agitation. Agitation could also be a**
5 **physiological response that's causing agitation,**
6 **you know.**

7 **Q** You said agitation can be a physiological response
8 that causes agitation?

9 **A** The terms are not interchangeable, but they have a
10 significant degree of overlap. Anxiety is more
11 reflective of a psychological or an emotional
12 state that's causing agitation; whereas, agitation
13 in its own right is actually the observed
14 behavior.

15 **Q** A behavioral trait.

16 **A** (Witness nods.)

17 **Q** Yeah.

18 MR. GUSE: John, when you get to a good
19 breaking point, it might be a good time. We've
20 been going about an hour and a half.

21 MR. PFLEIDERER: Sure.

22 MR. GUSE: At a good breaking point now?

23 MR. EDMINISTER: I'm not sure he
24 answered verbally to that last question, by the
25 way. Did you get that, Rosanne?

1 THE STENOGRAPHER: I said "witness
2 nods."

3 MR. EDMINISTER: "Witness nods."

4 MR. PFLEIDERER: Thanks, Mike.

5 **A Yes.**

6 MR. PFLEIDERER: Are we okay to change
7 the nod to a yes?

8 MR. GUSE: So stipulated.

9 VIDEOGRAPHER: We are going off the
10 record at 2:29 p.m.

11 (Brief recess taken from 2:29 p.m. to
12 2:44 p.m.)

13 VIDEOGRAPHER: We are going back on the
14 record at 2:44 p.m.

15 BY MR. PFLEIDERER:

16 Q Hi, Dr. Shokar. Before we went on break we were
17 discussing this October 12th note that you
18 dictated at 10:18 a.m.

19 We talked about family helping with
20 some of these anxiety or agitation issues.

21 Do you remember that?

22 **A Yes.**

23 Q When you did the observation that led to the
24 creation of this note, was there any family in the
25 room with Grace?

1 **A** I thought I saw Jessica, but I can't -- honestly,
2 I can't definitively remember if she was in the
3 room that day or the next day. I thought she was
4 in the room, though. If I was to say, I would
5 think she was in the room that day, yes.

6 **Q** I don't want you to guess.

7 **A** But again, I can't definitively say, yeah.

8 **Q** Okay. Continuing along with the subject of
9 anxiety.

10 In October of 2021 while you were
11 treating Grace, were you aware of any effects an
12 anxiety could have on oxygen levels or oxygen
13 consumption levels in a person with compromised
14 pulmonary function?

15 MR. BIRNBAUM: Object to the form.

16 **A** Yeah. Can you -- 'cause I thought I just answered
17 that.

18 BY MR. PFLEIDERER:

19 **Q** In October of 2021 while you were treating
20 Grace --

21 **A** Um-hmm.

22 **Q** -- were you aware of any effect that anxiety could
23 have on oxygen consumption in a person with a
24 compromised pulmonary system?

25 **A** Yes.

1 Q Okay. And what would that effect be?

2 A As I was mentioning before, anxiety, if it
3 increases the respiratory rate, you could have a
4 decrease in the oxygenation if you have an
5 alteration of your blood gases.

6 Q And is that because the oxygen consumption is
7 increased during anxiety?

8 A That's a part of it. But also your PCO₂, which is
9 your carbon dioxide, also goes down, as you blow
10 off more carbon dioxide in hyperventilation.

11 Q Is that why you said here on Plan No. 3, her last
12 ABG revealed normal PCO₂ and do not expect that
13 the elevated respiratory rate or hyperventilation
14 is impairing her oxygenation at this time.

15 Is that why you determined that it
16 was not -- that the oxygenation was not impaired
17 was that CO₂ level?

18 A That's the objective part of when I evaluate for
19 hyperventilation, if I have an ABG available, I
20 can use that objective data to determine if
21 there's actually truly a level of hyperventilation
22 high enough that's going to physiologically affect
23 the body. She was hyperventilating, but at that
24 assessment it was not to a level in which it was
25 impairing her carbon dioxide level.

1 Q Let's look at No. 6 under Plan. Do you see where
2 it says PT, OT?

3 **A Um-hmm, yes.**

4 Q What does that mean?

5 **A Physical therapy, occupational therapy.**

6 Q And when you say physical therapy, occupational
7 therapy, what are you saying? You're going to try
8 to get physical therapy into the room or that they
9 had been in the room?

10 What does that mean under Plan?

11 **A It's a part of her overall plan, if she got to the**
12 **point where physical therapy and occupational**
13 **therapy can assist, increase her, you know, the**
14 **deficits in which this illness had given her, to**
15 **increase her strength and the rest of her ADLs, or**
16 **active daily living, you know, measures. You**
17 **know, it's something that we do for all**
18 **hospitalized patients who end up inpatient,**
19 **particularly prolonged stays, 'cause most of these**
20 **patients develop some kind of debility physically,**
21 **and so it's always a part of my treatment plan.**

22 Q During the time you were treating Grace, did
23 physical therapy ever get involved with Grace's
24 care? Did she get to the point where that was
25 possible?

1 **A** **Not the days in which I saw her. I didn't -- I**
2 **don't think they would have been able to engage**
3 **with her. But they would make their own**
4 **assessment, you know, to determine if that's -- if**
5 **she was able to do that. But it's -- as far as I**
6 **know, it was not something that was of precedence**
7 **for the plan on those days.**

8 **Q** **During the time you were treating, did**
9 **occupational therapy, were they able to get**
10 **involved, to your knowledge?**

11 **A** **Not that I'm aware, and I don't think they did.**

12 **Q** **Okay. On October 12th, when you made the**
13 **observations that led to the creation of this**
14 **note, did you have any indication that Grace was**
15 **going to die in the next day or two?**

16 **A** **No. There's a possibility, but from the**
17 **assessment up until 10:00 when this note was**
18 **dictated, my first time seeing her, and from the**
19 **report I had been given, I was hopeful that she**
20 **would continue on BiPAP and recover.**

21 **Q** **I'm going to hand you what's been marked as**
22 **Exhibit 71. Do you have the exhibit?**

23 **A** **I do.**

24 **Q** **Do you see a 71 there at the bottom?**

25 **A** **I do.**

1 Q This note purports to be authored by you.

2 Do you recognize this note?

3 **A I do.**

4 Q Did you author this note?

5 **A I did.**

6 Q Take a second to read it, if you want, but my
7 question is: Does this note appear to be a true
8 and accurate representation of the note that you
9 authored?

10 MR. BIRNBAUM: John, what is the Bates
11 number on that document?

12 MR. PFLEIDERER: This is Ascension
13 00018.

14 MR. BIRNBAUM: Okay, thanks.

15 **A Yes.**

16 BY MR. PFLEIDERER:

17 Q Your answer is yes? True and accurate?

18 **A Yes.**

19 Q Okay. The date of service on this note is
20 October 12th, 2021. Do the notes in the document
21 relate to Grace's condition on October 12th, 2021?

22 **A Yes.**

23 Q And the time of dictation of this note appears to
24 be, sorry, 1646 hours or 4:46 p.m. Do the notes
25 of this document relate to Grace's condition and

1 activities taking place on or about that time on
2 October 12th, 2021 or just before, as you
3 clarified earlier?

4 **A As I clarified before, be previous to the notes**
5 **dictation and in the time between the previous**
6 **dictation.**

7 Q I'm looking at -- it's all one paragraph, so I'm
8 going to try to direct you here.

9 You state at the end of the fourth
10 line, beginning with "initially" -- do you see
11 that?

12 **A Yes.**

13 Q Okay. You state, "Initially discussed with Cindy,
14 the patient's mother, in regard to goals of care
15 in regard to worst case scenario if she was
16 requiring intubation, and she deferred me to her
17 husband Scott."

18 Did I read that correctly?

19 **A Yes.**

20 Q Okay. The first "she" there would be Grace,
21 correct?

22 **A Yes.**

23 Q And the second "she" is referring to Cindy Schara,
24 correct?

25 **A Yes.**

1 Q Okay. Do you remember having this discussion with
2 Cindy?

3 **A Yes.**

4 Q Okay. Do you remember where you were when you had
5 this discussion?

6 **A I was in the hospitalist room.**

7 Q The hospitalist room, you said?

8 **A Yes.**

9 Q Is that a room for multiple hospitalists or just
10 your office?

11 **A It's a room for multiple hospitalists.**

12 Q I'm assuming that this conversation was by phone
13 and that Cindy Schara was not also in the
14 hospitalist room with you?

15 **A It was by phone.**

16 Q Is it safe to assume that no one from the Schara
17 family was with you at the time you made this call
18 in the hospitalist room?

19 **A Correct, yeah.**

20 Q Okay. Do you remember anyone that was in the room
21 with you when you made this call?

22 **A Yes, there were some of my fellow hospitalists
23 that was in the room.**

24 Q Any nurses?

25 **A No.**

1 Q Are there ever nurses in the hospitalists room?

2 A No.

3 Q Special room, huh?

4 A I'll take that back. We have our own nurses that
5 work with us, but they are of a different role.
6 They're not, I'm assuming, the nurses you're
7 talking about.

8 Q Sort of like administrative sort of nurses?

9 A Yeah, more for helping with cares at discharge,
10 that kind of thing.

11 Q Was anybody with you on the phone? And by that I
12 mean on your end in the hospitalist room, were you
13 conferenced with somebody at the table with you?
14 Was there someone else from the hospital
15 participating in the call with you?

16 A No.

17 Q You said that you remembered this discussion with
18 Cindy Schara.

19 Was there anyone else on the line
20 that you were aware of?

21 A No.

22 Q Do you remember approximately how many minutes
23 this phone call lasted with Cindy Schara?

24 A Probably about 10 to 20 minutes, ish, around maybe
25 closer to around 10.

1 Q So your testimony would be about ten minutes?

2 A Yes, I think that's fairly accurate. It's --
3 honestly, it's hard to say because it was -- I
4 mean, I made a second call after that and, you
5 know --

6 Q Do you remember anything -- I guess I should
7 start -- strike that.

8 What was your purpose for calling?
9 Did you initiate the call? I'm sorry.

10 A I did.

11 Q Okay. Why did you initiate the call? What was
12 the purpose?

13 A Um, it's kind of a long answer. If you bear with
14 me, I can kind of get to that point.

15 Q Sure.

16 A Okay. The -- there's two aspects of care that I
17 was looking at. One was obviously the clinical
18 aspect, trying to do the best we can to help
19 Grace. The other aspect was to, as she was -- she
20 had a POA. She had -- her parents were making her
21 decisions for her. To understand what they would
22 want in, as I write, worst case scenarios, and the
23 worst case scenario being if she crashed, if she
24 basically had, you know, the need for
25 resuscitation efforts.

1 And up until that point, my
2 understanding was that verbally the Schara family,
3 or Scott, had indicated to my previous physician,
4 Dr. Baum, that -- I think it was, yeah, Dr. Baum
5 or, you know, and I'm not sure who else, that he
6 didn't want her intubated.

7 However, we didn't really have, and
8 this is by report when I had a sign-out with Dr.
9 Baum, a very clear understanding of the direction
10 of care, you know, for -- for in worst case
11 scenarios and moving forward.

12 And so what I do, and one of the
13 purposes -- one of the main things I could offer
14 in her case, given the fact that we didn't have
15 much additional medications to help her in her
16 particular state, it was a lot of supportive care,
17 one of the things that I could offer was a
18 significant amount of time to reestablish a
19 rapport with the family, which at that point it
20 seemed like there was a lot of, you know, events
21 of hostility or problems with previous personnel.

22 And so I wanted to kind of have a
23 fresh new angle, have, you know, a true, open,
24 honest conversation, open forum, non-rushed,
25 answer as many questions as possible. And those

1 things take time. And those are called goals of
2 care conversations when you go over, you know,
3 what to do when -- you know, worst case scenario,
4 if someone is going to crash, but also, you
5 undergo, you know, what to do in other scenarios
6 or circumstances if the desired outcome, which is
7 recovery, is not obtained.

8 And so I initiated this call to
9 initiate this conversation with who was the POA at
10 that time, Cindy, you know, who I was instructed
11 was the one I was supposed to contact first
12 from -- from, you know, from my previous physician
13 and Dr. Baum.

14 And so that's who I called first to
15 figure out, you know, this aspect of care, which
16 was -- which was not solidified and very
17 important, given the fact that, you know, as
18 events continued through the day here, as you see
19 that her BiPAP settings had increased, that her
20 condition had actually changed, and so we really
21 needed to solidify a plan for that instance.

22 Q And by plan, are you referring to code status?

23 A I'm referring to our goals of care, which includes
24 code status. It's only one portion of a goals of
25 care conversation.

1 Q Are there designated other portions?

2 A A goals of care discussion is designed in a way in
3 which we can bridge understanding of both parties.
4 It's designed to first understand where the
5 patient's side is coming from, what they
6 understand of their condition, what their insight
7 is, what their gaps in knowledge is, and then it
8 is -- the next step is to provide as much
9 information to fill those gaps so that when we're
10 both on the same page, we can come to a reasonable
11 and informed decision about what to do next.

12 And so the conversation, the goals
13 of care conversation, that was the purpose of the
14 call.

15 A portion of that is to clarify the
16 worst case scenario, which is, you know, if she
17 crashes in the hospital, you know, what do we do?
18 Because by default, we resuscitate, and
19 resuscitation efforts generally incorporate CPR,
20 the use of things like defibrillators or
21 medications to help with the blood pressure and
22 intubation. And it's usually all in tandem. And
23 you can have a split type of approach, but those
24 split-type approaches are kind of case by case
25 after you -- given all the information having one

1 of these goals of care conversations.

2 So my objective for calling Cindy
3 was to initiate a goals of care conversation so
4 that we can be all on the same page and I can
5 personally understand if they had insight into the
6 condition and had reasonable informed consent to
7 make a decision.

8 Q Got it. I'm going to sort of just continue
9 through this note. Okay?

10 A Sure, sure. Yeah.

11 Q Where we were reading before, starting on the
12 fourth line, it continues to say that she, being
13 Cindy, deferred me to her husband Scott.

14 Is that how you remember it today?

15 A That's a summary.

16 Q I mean, just that specific fact, not the whole
17 conversation. But ultimately, she deferred you to
18 her husband Scott; is that correct?

19 A Yes. As the conversation continued as I was
20 discussing her status through the day, you know,
21 where she was at there in regards to her increased
22 requirements for BiPAP, the first part of the
23 conversation is always the clinical, you know,
24 status of the patient at that time.

25 And then I led into the goals of

1 care conversation, as I previously had talked
2 about. However, I was unable to continue that
3 goals of care conversation because Cindy was,
4 understandably, quite emotional. She had cried on
5 the phone, and she then requested that I call
6 Scott instead and defer to him, because she --
7 essentially, she just couldn't continue the
8 conversation.

9 Q Did you ever specifically discuss a
10 do-not-resuscitate code status or a DNR code
11 status with Cindy on that first call?

12 A The conversation was heading that way, but, you
13 know, the terminology may have been presented but
14 there was -- there was no appropriate discussion
15 about DNI/DNR with Cindy at that time, again,
16 because she didn't have, you know -- she wasn't
17 ready to talk about it, essentially. And again,
18 she was really wanting Scott to talk about it on
19 her behalf. And so approaching her about do you
20 want to intubate her or -- you know, in these
21 situations and, you know, after trying to embark
22 on that conversation, I was unable to get through
23 that I guess that -- that idea to have a formal --
24 to even consider a formal answer at that time.

25 Q You mentioned earlier that at the time that you

1 wrote this history and physical report that the
2 condition had changed; is that correct? Am I
3 remembering correctly, Grace's condition had
4 changed?

5 **A Yes. From 10:00 in the morning onwards, as you --**
6 **you know, as I've written, you know, her oxygen**
7 **requirements increased, her BiPAP settings had**
8 **increased.**

9 **Q** So at the time that you made the observations that
10 led to the creation of this history and physical
11 report, did you believe at that time that it was
12 likely that Grace was going to die in the next day
13 or two?

14 **A** It was more probable, for sure. I mean, she was
15 on max presser settings. The conversation of
16 goals of care and code status became ever more
17 pressing at that point. She was no longer -- my
18 initial morning assessment was ABG may be
19 improving, she's calm and comfortable. My report
20 overnight, no events, everything's kind of status
21 quo, you know, hopefully we can give her more time
22 to recover. Now all of a sudden she's getting
23 worse, and her oxygenation is worse and her BiPAP
24 settings go up. So now the time that we have to
25 kind of figure out goals of care shortens.

1 Q In your recollection or in your review of the
2 medical record, is there anything that you think
3 caused this change, or was this just the
4 progression in Grace's disease or condition?

5 **A At the time of the deterioration, I felt it was**
6 **likely a progression of her condition. And then**
7 **in retrospect, when the next day -- you know, on**
8 **the 13th, it was -- it was confirmed in my mind**
9 **that it was, most likely that was the case.**

10 Q Did you entertain any other possibilities besides
11 the progression of the disease?

12 MR. GUSE: Object to the form of the
13 question as vague, ambiguous.

14 MR. PFLEIDERER: You can answer.

15 **A I'm assuming you're alluding to like an additional**
16 **superimposed infection or something like that?**

17 BY MR. PFLEIDERER:

18 Q That, sure, that could be one thing.

19 **A Sure, yeah. In the back of my mind, yes, but most**
20 **likely a progression of disease.**

21 Q Did you do anything to investigate whether there
22 was a superimposed infection at the time of this
23 deterioration?

24 **A Not at that moment as we had data already**
25 **presented from that day and the day prior.**

1 Q What data specifically are you referring to?

2 A Her blood counts, you know, CBC, her electrolytes,
3 and the x-ray from the day prior had already been
4 reviewed.

5 Q Did you consider that the drug Precedex -- strike
6 that.

7 Were you aware at the time that you
8 made observations that led to the creation of this
9 note that Grace was receiving Precedex?

10 A Yes.

11 Q Okay. Did you consider whether the Precedex that
12 Grace was receiving led to the deterioration of
13 her condition?

14 A It was considered but a low likelihood at that
15 time, and felt the benefits of using the Precedex
16 to help with the respiratory agitation outweighed
17 the possibility of it causing, you know, the
18 respiratory distress, particularly because she was
19 tolerating the same medication for -- previously.

20 And, you know, the one thing that I
21 look for in someone who's having issues with
22 Precedex is seeing, you know, sedation and
23 bradycardia being the more probable adverse
24 effects of that medication.

25 You want me to continue?

1 Q I'm here to listen to you.

2 A The other thing is that, you know, we didn't -- we
3 don't have many tools to kind of help with the
4 agitation aspect of things. As I was alluding to
5 before, we have Precedex, which is the favorable
6 medication given its ability to be turned off
7 quickly, you know, and more favorable in an ICU
8 setting.

9 We have Ativan or another
10 benzodiazepine which has a longer half-life, which
11 is kind of secondarily preferred. And so if I was
12 to turn off the Precedex, it would have to be for,
13 you know, a reason in which I was seeing the need
14 for. At that time I didn't feel that the Precedex
15 was the cause of her condition deteriorating that
16 afternoon. But it's something that, as I say is
17 in the back of my mind, because I need more time
18 usually to see and assess and see what's going on.

19 I mean, if we -- as time went on,
20 we're noticing a trend that supports the
21 medication being the reason for it, in which case
22 then we would remove that medication. But at the
23 time, all I was seeing was a worsening respiratory
24 function.

25 Q You mentioned that Precedex was a drug that Grace

1 had tolerated previously, correct?

2 **A Yes.**

3 Q Okay. During your time treating Grace on the 12th
4 and the 13th, were you aware of Grace during her
5 stay at St. Elizabeth having any adverse reactions
6 to Precedex?

7 **A No.**

8 Q Did you --

9 **A Can I rephrase? On the 12th and the 13th?**

10 Q Yes.

11 **A The 13th, yes, the time I went in on the 13th and**
12 **I turned off the Precedex when she was having some**
13 **issues, that's when I had suspected Precedex may**
14 **be a cause of -- a potential cause of bradycardia.**
15 **I didn't want to continue that medication given**
16 **her heart rate had started going down. So at that**
17 **point was the first time. But prior to that**
18 **event, no.**

19 Q Do you remember what time you turned off the
20 Precedex?

21 **A That was on the 13th when I had entered the room**
22 **in the p.m. of the 13th when she was hypoxic for**
23 **quite some time and we were trying to improve her**
24 **oxygenation. It was --**

25 Q We can jump ahead.

1 A 5:00, 5:30.

2 Q Is there a particular note you want?

3 A The 13th note would help. The -- it was in the
4 event that -- you know, the -- it was 5:30, I
5 believe I was in the room.

6 Q Nope, that's mine. I'm sorry.

7 A But you can correct me on the time.

8 Q You want your progress note from the 13th? Is
9 that what --

10 A I don't know if it's listed -- if the time that I
11 was in the room is listed in the progress note.
12 But, yeah, that might help. I mean, I believe it
13 was --

14 Q You can hold onto it.

15 A Thank you.

16 Q Nothing?

17 A No, not in the progress note. Again, that was the
18 event prior -- the same event in which I was
19 called to the room because Grace was hypoxic, in
20 the 50s. It was in the p.m. of 10/13.

21 Q You're talking about SPO2 of 50s?

22 A Correct, yes. She was SPO2 of 50s. I was called
23 to room by nursing to evaluate further. It was --
24 I would say be around 5:30 or so, 5:50-ish maybe,
25 in the evening. When I entered the room on my

1 primary survey, I had noted that her oxygenation
2 was indeed 50 -- about 55 percent on the hospital
3 oxygenation machine, but she had two other oxygen
4 monitors on her at that time, a portable oxygen
5 machine that was at 85 percent, and a finger
6 oxygen machine that was at 99 percent or
7 95 percent, a finger pulse ox that was brought
8 from home.

9 And on the monitor it had recorded
10 that her heart rate was in the 50s. And at that
11 point I turned off the Precedex, given the verbal
12 order to turn off the Precedex.

13 Q Sure. And I don't want to mischaracterize, but to
14 summarize what you're saying is you turned off the
15 Precedex in response to Grace becoming hypoxic?

16 A Bradycardic.

17 Q Oh, bradycardic. And at that time did you know
18 bradycardia to be a potential adverse side effect
19 of Precedex?

20 A Yes.

21 Q At that time did you know hypoxia to be a
22 potential adverse side effect of Precedex?

23 A CNS and respiratory depression, yes, it's
24 uncommon.

25 Q When you say uncommon, what do you mean by that?

1 A I mean, again, in a differential figuring out what
2 are the reasons for someone to be hypoxic, all of
3 these probability -- all of these possibilities are
4 on a differential, but we have to weight them
5 based off of what's the most probable. And
6 Precedex causing acute respiratory failure, as she
7 had been on it for a while, and its rate of
8 respiratory depression, I believe, is like 2 or
9 3 percent as far as I remember.

10 Q Two or 3 percent of Precedex causing acute
11 respiratory failure?

12 A Of it causing an issue in regards to respirations.
13 Much more commonly if you're going to have a side
14 effect it will be bradycardia. Hence, why more
15 commonly I look for bradycardia, but it is on the
16 differential. Much lower. If you have a poss --
17 if you have something more probable, that's what
18 you go with.

19 Q When you're determining these differentials -- and
20 you keep saying "probability" a lot.

21 A Um-hmm.

22 Q What sort of data are you looking at to make these
23 probability calculations in your differentials?

24 A It's essentially what essentially makes a doctor,
25 to be honest. I mean, what you're asking is what

1 we learn in medical school and what we practice.
2 What we practice is someone coming in with a
3 condition, and we're not just saying it's this,
4 it's definitely this, 100 percent.

5 What we're doing is we're creating
6 a list of possibilities. You have five conditions
7 that could be causing your problem. And then we
8 weight it based off of the tools that we have,
9 which is labs, imaging, you know, we -- anything,
10 any evidence that we can bring. We use that
11 information to then weight our differential
12 diagnosis and what's the most probable to the most
13 least probable. We use that information to rule
14 out the least probable, you know, in order so that
15 we arrive at only one or two diagnoses.

16 So every time I have a problem, I'm
17 basically in my mind weighting these differential
18 diagnoses. Because medicine's never 100 percent
19 it's this, unless it's 100 percent that with a
20 biopsy or something like that.

21 You know, so that's why I keep
22 alluding to the possibilities and probabilities.
23 In her case, hypox -- we -- the hypoxia she was
24 suffering from, the probability of it being from a
25 escalation of her post-viral syndrome from COVID

1 was much, much, much higher than any other
2 differential, yet the differentials exist in my
3 mind and -- you know, as possibilities. I didn't
4 have enough evidence to support -- and when I say
5 evidence, I mean I take all of this information
6 and I use my expertise and my training to -- to
7 make a clinical judgment. And that's why I say my
8 clinical impression. I make a clinical judgment
9 to figure out, you know, what is the most likely
10 reason and what we need to intervene on first, and
11 then what we can order on the background to kind
12 of rule out or rule in things.

13 Q So I understand a lot of what you're saying is
14 that you gain these evaluation tools through
15 experience; is that correct?

16 A Yes, and study.

17 Q And study. Okay. What kind of things are you
18 studying to help form these differentials?

19 A I mean, it's pretty -- I've studied my whole life.
20 I mean, starting from, as you know, my undergrad
21 selection, my medical school, residency, my
22 clinical experience in -- you know, through COVID,
23 you know, in the pulmonary IMC, you know, you --
24 you see patient encounter after patient encounter.
25 You gain an understanding of how diseases, you

1 know, deviate from textbooks as a clinical or
2 standard classical presentation, and then you see,
3 as encounters go on, you know, all the different
4 ways in which a patient can present and progress.

5 And there's many, many factors that
6 are, you know, modified how a disease progresses.
7 Again, they don't all travel the same way. That's
8 just the majority of them travel one way.

9 So it takes patient encounters, it
10 takes experience, it takes understanding of the
11 disease process. You know, physicians are
12 generally lifelong learners. We do continuing
13 medical education. You know, we always try to
14 keep up with our skill-set or, you know, at least
15 you should. And that's -- I always strive to do
16 it. That's what I do.

17 Q Have you ever read any studies that specifically
18 discuss the use of Precedex?

19 A I read studies about Precedex use. There's not
20 many of them, to be honest. You know, you have
21 different levels of educational material from
22 primary sources to summary papers, you know, that
23 kind of summarize all the primary material.

24 Q Could you tell me any of the studies that you've
25 reviewed in regard to the use of Precedex?

1 A Not off the top of my head, I can't quote a study.

2 Q I'm asking a site of study.

3 A Precedex in the use of ventilated ICU patients,
4 Precedex in the use of non-ventilated patients
5 with agitation. You know, I think those are
6 really the only two. But this is quite a while
7 ago, and it's not a medicine that I prescribe
8 myself. It's an -- it's usually an ICU medication
9 that's used in the ICU, in an ICU setting, because
10 it does need to have, you know, monitoring
11 associated with it.

12 Q Why is that?

13 A Because it's just -- it's on a drip formulation
14 that needs to be titrated up and down, and usually
15 you need to have a nurse do that watching for side
16 effects, essentially. I'm obviously aware of the
17 medication and I know about its side effects and
18 adverse events --

19 Q Well, you were using it in your practice in
20 October of 2021 while you were treating Grace,
21 correct?

22 MR. GUSE: Object to the form of the
23 question.

24 A She was on Precedex as a part of her care
25 management. I was aware that she was on Precedex

1 **and I was -- in consideration of her treatment**
2 **plan, you know, I took that as a factor.**

3 BY MR. PFLEIDERER:

4 Q You said earlier that you -- I think you said took
5 over Grace's care from either Dr. Baum or you said
6 it could be somebody else?

7 A **It was Dr. Baum, yeah.**

8 Q Okay. When you, as you said, take over the care
9 of a patient --

10 A **Um-hmm.**

11 Q -- do you review that patient's chart as it
12 relates to their stay at the hospital before you
13 took care?

14 A **Generally what happens is there's a sign-out the**
15 **night before. So I was talking to Dr. Baum on the**
16 **phone the night prior to my start date, which was**
17 **October 12th. And we run the list of patients and**
18 **highlight any, you know, management care plans or**
19 **any, you know, things that we need to address.**

20 **On my day's start, that's when I**
21 **review the record, and, you know, start looking at**
22 **previous notes and, in large, what the daily**
23 **assessment -- what the assessment is for the day.**
24 **I go see the patient, and then continue**
25 **formulating or continue with the management care**

1 **plan that's appropriate.**

2 Q And did you do that in Grace's case?

3 A **I did.**

4 Q Okay. And did you review the nurses' notes when
5 you took over Grace's care?

6 A **Partially reviewed nursing notes, because the
7 record that she was -- she was on like Day 15.
8 That's an enormous undertaking to review a whole
9 note --**

10 Q You mean Day 15 of her admission to the hospital?

11 A **Yes, correct, yeah. She was there for quite some
12 time. I usually go back when I have, you know,
13 seen all my patients, you know, and kind of
14 addressed all the immediate problems for them,
15 then I'll go back and start reviewing more data
16 that was not rele -- you know, as relevant for
17 that day's care.**

18 So, for instance, in Grace's case,
19 I reviewed all the notes for the day -- the day --
20 for the day prior and, you know, a couple days
21 prior which would have included the nursing notes,
22 yes.

23 Q And would you have eventually reviewed the nursing
24 notes for all 15 of the prior days?

25 A **Eventually, yes.**

1 MR. GUSE: I'm going to object to the
2 form. It misstates the evidence. She was not in
3 the hospital for 15 days at this point.

4 MR. PFLEIDERER: Well, he just
5 testified --

6 MR. GUSE: Counselor, you know that
7 that's not true.

8 MR. PFLEIDERER: Who is to say whether
9 it's true or not?

10 MR. GUSE: Because you have --

11 **A Five days, yeah.**

12 MR. GUSE: -- you have the records.

13 MR. PFLEIDERER: I'm asking what he
14 remembers about the record. You're coaching him.

15 MR. GUSE: No. You are intentionally
16 misleading him by --

17 MR. PFLEIDERER: I'm only saying his own
18 testimony. That's it. I think you are leading
19 him.

20 MR. GUSE: No.

21 **A Sorry. I'm going to revise. Fifteen days from**
22 **COVID onset, as far as I understand. I don't know**
23 **why the 15 was stuck in my head there. But she**
24 **was in the hospital since the 7th, it seems, you**
25 **know, so it would have been five, six days of**

1 **notes. And yes, I would have gone through all the**
2 **notes at some point.**

3 BY MR. PFLEIDERER:

4 Q When you reviewed the notes, did you ever see any
5 nursing notes about an adverse reaction to
6 Precedex?

7 **A No, not that I recall.**

8 Q Are you aware that Precedex is manufactured or was
9 developed by Pfizer?

10 **A I was not aware of that.**

11 Q Okay. Have you ever reviewed any information from
12 the manufacturer of Precedex?

13 **A You mean the drug information sheet?**

14 Q Yes.

15 **A A long time ago. I don't know exactly when, but**
16 **at some point I did.**

17 Q Were you aware while treating Grace in October of
18 2021 that respiratory failure was a possible
19 adverse effect of Precedex when used for longer
20 than 24 hours?

21 MR. GUSE: Object to the form of the
22 question. Vague, ambiguous.

23 MR. PFLEIDERER: You can answer.

24 **A I think you're alluding to the manufacturer**
25 **warning, which has been further studied and, you**

1 know, it is a possibility, but it's been used up
2 to 14 days in ICU patients without any -- you
3 know, as a safer alternative to benzodiazepine, so
4 again, you have to weigh the risks and benefits.

5 BY MR. PFLEIDERER:

6 Q I'm not saying it was unsafe; I'm just asking if
7 you know that it was a possible adverse side
8 effect if used for longer than 24 hours?

9 A According to the initial manufacturer's data, I
10 believe that was listed as that. But as I was
11 saying, they've done studies afterwards which
12 decreased the concern of that being a limitation
13 to using it past 24 hours.

14 Q What studies are those? Can you cite any?

15 A That is from a summarization now of literature
16 that would be presented on, you know, physician
17 information databases such as Lexicomp, you know,
18 drug or -- basic Lexicomp, yeah.

19 Q Do you have any such studies in your possession,
20 not here, but anywhere?

21 A Like physically?

22 Q Like to copy on your computer or you printed a
23 copy or it's in your office or something like
24 that.

25 A I don't need to keep those copies because we're --

1 I have subscription services to services like
2 Lexicomp that will give me this information
3 readily accessible when I look for it.

4 Q Okay. You referenced, did you call it the
5 manufacturer drug information? What did you call
6 the document that you're referring to?

7 A It's kind of like the initial drug information
8 that gets presented for when the drug gets first
9 released.

10 Q Something you'd pull from the FDA?

11 A Yeah, and it's -- well, it would be the FDA one.
12 And the reason it's been referenced for Precedex
13 is because of that change in the initial use of
14 Precedex, which was initially for only 24 hours
15 given the FDA approval, you know, recommendation
16 at that point.

17 But -- and the reason I know this
18 is because in questioning previously, you know,
19 'cause many patients have been on Precedex more
20 than 24 hours, it was something that was brought
21 up and say, well, why are we using it more than 24
22 hours. And I was educated on the fact that it can
23 be used more than 24 hours, you know, because
24 they've done repeat studies to show that. And
25 then I verified that that was the case, you know,

1 from secondary sources of information such as
2 UpToDate or, you know, those kind of sources that
3 kind of summarize medical literature.

4 Q Based on your study of these various sources that
5 you've listed --

6 A Um-hmm.

7 Q -- is it your understanding that the risk of
8 serious or nonserious adverse side effects
9 increases when Precedex is used past 24 hours, or
10 do you think it's the same, stays the same?

11 A I think any medication, when you use it, the
12 longer you use it, there's going to be more
13 concern.

14 Q Sure. Were you aware when you were treating Grace
15 in October of 2021 that agitation was a possible
16 adverse side effect of Precedex?

17 A No.

18 Q Were you aware in October of 2021 while you were
19 treating Grace that hyperglycemia was a possible
20 adverse side effect of Precedex? Hyperglycemia?

21 A No.

22 Q Were you aware in October of 2021 that fever was a
23 possible side effect of Precedex?

24 A Yes.

25 Q Were you aware in October of 2021 that hypotension

1 was a possible side effect of Precedex?

2 **A Yes.**

3 Q And you already mentioned bradycardia, right?

4 **A Um-hmm.**

5 Q Were you aware in October of 2021 that acute
6 respiratory distress syndrome also known as ARDS
7 was a possible side effect of Precedex?

8 **A Caveat -- respiratory depression as far as ARDS
9 goes like -- which is a particular syndrome, no.**

10 Q No, you were not aware?

11 **A Of the particular ARDS syndrome, which she was
12 already in. My general understanding of Precedex
13 was it has a possibility of, you know, impacting
14 the respiratory system, but as far as causing a
15 acute respiratory distress syndrome that is
16 defined as ARDS, no. That's a particular syndrome
17 and which you treat a particular way when you have
18 an inflammatory consideration in your lungs, you
19 know, that changes the way that you oxygenate.
20 It's well-known in the ICU and it's -- it has a
21 very high mortality.**

22 Q What was that last part?

23 **A Has a very high mortality.**

24 Q Mortality?

25 **A Mortality.**

1 Q ARDS you're referring to?

2 **A Correct. And it can happen with many, many**
3 **conditions, anything, really, that affects the**
4 **lungs.**

5 Q Okay. I think we had just finished talking about
6 the conversation with Cindy Schara that she had to
7 defer to her husband. Okay?

8 **A Sure.**

9 Q So I'm going to keep on moving. Am I to
10 understand from this note that you then did in
11 fact have a conversation with Scott Schara?

12 **A Yes.**

13 Q Okay. And how soon after, if you remember, was
14 that conversation after you got off the phone with
15 Cindy Schara?

16 **A I called him right after.**

17 Q Right after?

18 **A Um-hmm.**

19 Q Was Cindy Schara on the phone with Scott Schara
20 when you talked to him?

21 **A I assumed so, and I'll tell you why. I called**
22 **Scott. The initial portion of our conversation**
23 **was private. He then put me on speakerphone in**
24 **conference with his family and told me that, you**
25 **know, that his family was in the room.**

1 His son-in-law, I believe,
2 introduced himself. Another woman introduced
3 herself. I'm not exactly sure who that was. I
4 don't think it was Jessica. I think it was
5 another --

6 Q Could it have been Cindy?

7 A And then the reason I say Cindy is because when --
8 after I had -- we had this long conversation and
9 it was opened up to questions, you know, they went
10 around, said do you have any questions, asked --
11 everyone asked their questions, and then I
12 overheard them saying, Cindy, do you have any
13 questions. And so I'm assuming she was in the
14 room, but I do not recall her -- you know,
15 speaking to her during that conversation.

16 Q You just mentioned questions. What questions, if
17 any, do you remember the family asking you on that
18 call?

19 A They were generally vague questions to -- like
20 nonspecific questions just to clarify what had
21 been discussed. His -- his son-in-law asked a few
22 questions. I don't recall -- you know, they're
23 like confirmation answers rather than anything as
24 new material. So as far as the general
25 conversation played out, I mean, it was kind of

1 **the same --**

2 Q Maybe it would be better if we started with the
3 discussion then.

4 A **Yeah, harder for me to kind of jump to that.**

5 Q Sure, understand. Okay.

6 What's the first topic of
7 discussion that you remember from that conference
8 call?

9 A **Presented it exactly how I started to present to**
10 **Cindy, which was an update on her clinical**
11 **condition. This was the call on the 12th, I'm**
12 **assuming you're talking about?**

13 Q I'm referring to the call referenced in your
14 October 12th history and physical report.

15 A **Great. Okay.**

16 Q So you said update on clinical condition?

17 A **Correct. So --**

18 Q What was the clinical condition at this point?

19 A **At this point I had relayed information of her**
20 **increased BiPAP settings and escalation, you know,**
21 **through the day, how, you know, it was kind of a**
22 **status report of, you know, the events of the day**
23 **thus far.**

24 **Again, all this kind of alluding**
25 **toward the goal of cares conversation, so I had to**

1 kind of present the status that she was at at that
2 time, which was she was on BiPAP, you know, at
3 fairly high settings of 20 over 15. She
4 previously was on 15 over 12. Her FiO2 had
5 increased, you know, she's malnourished. We
6 should talk about nutrition, that kind of thing,
7 which we ended up doing. But the first kind of
8 concern was having that initial conversation about
9 goals of care.

10 Oh, we did talk about, you know,
11 modalities like proning to help her oxygenation
12 and optimizing that as well. The next part of the
13 conversation was more in regards to Scott's, I'd
14 say, kind of grievances with the care team thus
15 far.

16 Again, the idea of this
17 conversation was really to start fresh. Okay? So
18 it was really to -- I heard in report, for
19 instance, and I was trying to throw all that out
20 of the way to say, okay, let's -- obviously a
21 miscommunication, obviously issues, let's get --
22 you know, let's restart. And I had the
23 opportunity to do that as I was a new provider
24 coming in and, you know, and I wanted to spend
25 that time.

1 So the conversation after kind of
2 reporting how she was doing for that day, you
3 know, ended up being Scott telling me about the
4 events that had passed from his perspective. And
5 so that took up the next chunk of time which was,
6 you know, his concerns about having to leave the
7 hospital, all he was trying to do was turn alarms
8 off and the BiPAP, and they're telling me I'm
9 tampering with the machine, and that's not right.
10 And he was telling me, you know, about how, you
11 know, he felt like the nurses keep saying they're
12 giving -- they're going above and beyond, but he
13 doesn't feel they were, and there's a
14 misperception that they feel they are but they're
15 not actually doing that.

16 So -- and then he was -- he was
17 concerned that everyone kept on asking about
18 intubating Grace, and why -- why they keep telling
19 me about having these concerns and questions about
20 intubation, I don't want to intubate her. He, you
21 know -- but it was -- so the second part of that
22 conversation was basically that and me trying to
23 offer some solace and understanding to try to, you
24 know, again, not be biased in the assessment of
25 the preceding events because that could -- I

1 didn't want that to impair the trajectory of the
2 conversation and the decisions that we need to
3 make in collaboration, you know, in the future
4 like after -- and during that conversation.

5 So after that was all done, at some
6 point we got put on speaker, and now is about the
7 time when I started talking to him, you know, and
8 initiating my goals of --

9 Q Were you on speaker the whole time?

10 A I don't know when -- no, no. Initially it was a
11 private, it was just me and Scott talking, Scott
12 and I talking, and then at some point he said I'm
13 going to include -- I'm going to put you on
14 speaker and include my family. And that was when
15 I started talking about, you know, her condition
16 and the scenarios and trajectory of what could
17 happen.

18 And then in conclusion, after I
19 talked about the scenarios, you know, the
20 possibilities, after that was the code status
21 conversation. So it was kind of in that order.
22 Did you just want me to continue on the
23 conversation?

24 Q Sure. You're getting all my questions.

25 THE WITNESS: That's okay?

1 MR. GUSE: I prefer to have a specific
2 question on the table.

3 **A Okay. Well, I'll wait. I'll stop there then.**

4 BY MR. PFLEIDERER:

5 Q Okay. Sound's good. I kind of got some bullet
6 points there about what you were talking about.

7 First was update on clinical. We
8 were talking about your prior -- I know this is
9 H&P, but we talked about your prior note. And it
10 seemed like you were more optimistic at that time
11 for Grace's future.

12 **A Um-hmm.**

13 Q Am I correct in saying you were less optimistic at
14 the time this note was created?

15 **A I was concerned. I was definitely concerned.**

16 Q Okay, concerned.

17 **A She showed a deterioration through the day. I was
18 hoping it was a temporary deterioration and then
19 we can go back to the other settings. At least I
20 was hopeful it was a temporary consideration, but
21 I had to, you know, at least be -- have some
22 realistic weight and saying that this could be a
23 progression as well and we need to have these
24 conversations.**

25 Q And earlier I said at this point, did you think

1 that Grace would likely die in the next day or two
2 and you said it was more probable.

3 Did you express that heightened
4 probability to the family on the phone that it was
5 more likely that day that Grace would die in the
6 next day or two?

7 **A** In a way, yes. I mean, I didn't say exactly like
8 you just said it in regards to it's probable she's
9 going to die. The problem was I was reaching in
10 the context -- in a conversation structure which
11 was -- it had to be in an optimistic fashion. I
12 was talking to Scott about it. You know, he
13 really did not appreciate and like the negativity
14 that was surrounding the conversation, and
15 everybody kind of, you know, alluding to the fact
16 that she was going to die.

17 And I had to reapproach the
18 conversation with that optimism in mind to say,
19 listen, we're on the same page here, we want
20 recovery, we want her to get better, and I'm
21 treading carefully to say -- to not be like she's
22 going to die today. Right?

23 **Q** Sure.

24 **A** But I was informing him of the deterioration and
25 the level of BiPAP that she was on was extremely

1 elevated. I mean, these are very high settings.
2 And, you know, and the fact that she had been on
3 BiPAP for several days, and these are
4 conversations that need to happen now and I need
5 to have answers by this evening, as I documented
6 as well, that she could crash any time. And, yes,
7 if we have time, we can work things out, we can do
8 things, and, you know, that's an allusion to the
9 scenarios I presented him.

10 But, you know, I can't predict if
11 she's going to crash at any moment, and she can
12 crash today, she can crash overnight. I tell them
13 we need to know this before tonight. I'm not here
14 tonight, you know, can I have an answer for what
15 you want to do in that worst case scenario if she
16 crashes, you know, so that -- so in the
17 conversation, the context of the conversation
18 would have alluded to the fact that it was very
19 severe, you know.

20 I think a reasonable assessment or
21 understanding of that conversation would have
22 assumed that this was severe. The fact that Cindy
23 was crying when I was starting to talk about this
24 means it was severe. I was under the impression
25 that everyone knew this was a severe situation and

1 **she could.**

2 Q I want to correct what might be a typo here.
3 There's a line starting with you had called Scott.
4 Oh, yeah, right here. "I had called Scott and had
5 a family conference with him and his children in
6 regard to worst case scenario. BiPAP at max
7 settings was ineffective for."

8 Is there a word missing after
9 ineffective for?

10 **A I'm trying to find this. One second.**

11 Q Yeah, it's seven lines down. Nine lines down.
12 Sorry. It's on the left side.

13 **A Yeah. I'm trying to read this. Hold on.**

14 Q Just go down the left side. There's a line
15 beginning with ineffective.

16 **A No, I'm reading it here.**

17 Q Sure.

18 **A I think it was just a typo. Or I mean the**
19 **dictation is exactly what I said, but --**

20 Q Are you saying the word "for" should not have been
21 there?

22 **A I'm not sure, to be honest.**

23 Q Okay. All right. That's fine.

24 You say further down here -- I'm
25 not sure how to get you there. The sentence

1 starts, "We spent over 60 minutes" -- sort of on
2 the right side of the paragraph.

3 **A Sure.**

4 Q You got it?

5 **A Um-hmm.**

6 Q "We spent over 60 minutes during this conference
7 to answer all questions that were posed and
8 counseled as best as possible in regard to the
9 unfortunate situation."

10 Are you saying here that the call
11 itself lasted 60 minutes or that the question and
12 answer session lasted 60 minutes?

13 **A The whole call.**

14 Q The whole call. And is that true to the best of
15 your recollection today?

16 **A It was roughly an hour. I mean, I don't have
17 exact times. It was a very long time.**

18 Q And now that we've sort of listed out these topics
19 here, is there any other comments from Scott
20 Schara that you can specifically remember
21 regarding grievances with hospital staff? I think
22 you mentioned grievances.

23 **A Let me think. I -- there were, but I'm just -- I
24 don't feel that I -- I know there were, but I
25 don't -- I can't recall them enough to tell you**

1 **for certainty.**

2 Q Okay. And then you mentioned that one of your
3 goals with this conversation was to have a fresh
4 start with the family.

5 Is it fair to say that you were
6 trying to improve the family's relationship with
7 hospital providers?

8 MR. FRANCKOWIAK: Objection to form.

9 MR. GUSE: Yeah, join. Vague and
10 ambiguous.

11 BY MR. PFLEIDERER:

12 Q I'll reask that. What do you mean by you wanted a
13 fresh start?

14 A **My impression was, is that the hospital experience**
15 **from the Schara family was not a -- one to their**
16 **expectation.**

17 Q Okay.

18 A **And I wanted to understand why and try to recover**
19 **some of that, what I assumed was like a feeling**
20 **that -- how do I say this? He was -- he had to**
21 **be, for instance, like removed from the hospital**
22 **and there was all these, you know, things that**
23 **happened prior, again, which I was trying to not**
24 **pay too much attention to when I had these**
25 **conversations.**

1 But I wanted to be a fresh provider
2 for him to kind of feel that he can connect with
3 and -- one of the jobs as a general -- like a
4 hospitalist is I'm like the liaison. I'm not just
5 a quarterback of the -- you know, trying to get
6 the care coordinated and everything like that, but
7 I'm the person that has the most experience in
8 conversations and the ability to communicate with
9 the family.

10 And the fact that when I had
11 rapport done was that they couldn't peg down, for
12 instance, code status and this and that, and there
13 was -- there were so many grievances, I felt like
14 I was in a good position as a new provider in to
15 kind of just go through it all, and let's -- let's
16 start fresh.

17 You obviously can't start fresh,
18 but as fresh as you can to kind of -- to try to
19 get to a resolution --

20 Q Sure. I understand. Sure.

21 A -- you know, and an understanding of what -- what
22 the family wanted.

23 Q Do you remember if on this call you ever
24 specifically used the term "do not resuscitate"?

25 A On this particular call the conversation in

1 regards to code status and do not intubate and do
2 not resuscitate largely revolved around do not
3 intubate, largely revolved around do not intubate.
4 I introduced the conversation about the futility
5 of CPR if you're not going to intubate in someone
6 who has irreversible causes and hypoxia. I
7 introduced do not resuscitation as a concept, but
8 the large amount of that conversation was about do
9 not intubate.

10 And the reason for that was,
11 because I'd introduced the conversations in tandem
12 with each other, at that time my assumption was
13 that talking about one in tandem with the other
14 one, they would understand that what we're really
15 trying to understand is resuscitation as a whole.
16 Are we going to intubate, are we not going to
17 intubate? If we're not going to intubate, you
18 know, then we're basically seeing if she improves
19 on BiPAP. And if she doesn't, then we have to
20 have a tough conversation about things like
21 comfort care, right? Because she's not going to
22 survive if she goes -- if she deteriorates and
23 you're not going to intubate her. Resuscitation
24 efforts are not going to be fruitful for her.

25 And so that -- those concepts are

1 introduced, but the explanation of do not
2 resuscitate happened the next day, you know, after
3 it was apparent that -- you know, Scott, he needed
4 more clarification on the do-not-resuscitate
5 aspect of CPR and whatnot.

6 Q Did you ever -- strike that.

7 If Grace, I think you used the word
8 crashed, but had pulmonary failure, you know,
9 something like that, did you ever convey to Scott
10 that if Grace was not intubated that she was very
11 likely to die?

12 A I conveyed to him that she can crash any time.

13 Q Sure. Did you convey that if she were to crash
14 and not be intubated that she would -- I don't
15 know what probability -- but I'm going to say very
16 likely die, did you convey that to Scott?

17 A I'm pretty sure that I conveyed that intubation --
18 if you're -- I really -- okay. I conveyed to him
19 that if she's hypoxic, you know, and we can't
20 reverse that with BiPAP, that her only method of
21 oxygenating would be intubation. And that flowed
22 into a conversation as far as if she crashed, then
23 she needs to be -- then she would be intubated to
24 restore her oxygenation as best as possible.

25 And if we're not going to intubate

1 her and she crashes, then they're not going to
2 intubate her at that time either, because
3 you're -- you don't want her intubated.

4 But I'm telling -- I implored the
5 fact that I cannot predict when she's going to
6 crash but she has the potential of crashing. That
7 day, that night, you know, I need to know an
8 answer as soon as your family can convene an
9 answer, and I requested that, you know, I had that
10 information by the night.

11 And he delivered it the next
12 morning, and then we had a follow-up conversation
13 the next morning about, you know, that
14 incorporated that and more, because that
15 conversation as well was about 45 minutes or so.

16 Q I think you said a moment ago that if Grace were
17 to crash and she was not to be intubated, then you
18 would have to have a difficult conversation about
19 comfort care.

20 Am I remembering that correctly?

21 A I think you're confounding the two.

22 Q Sure.

23 A Do you mind if I clarify?

24 Q No, I don't.

25 A The conversation -- a big meat of the

1 conversation, and I believe this was also on
2 conference, I was going over the scenarios of what
3 could happen moving forward. Okay? And I was
4 going over, you know, if she's on BiPAP and she --
5 the best scenario is for her to be on BiPAP and
6 she gets better. Right? Settings go down, we
7 wait, we wait, we wait, things get improved.

8 The second scenario is that she's
9 on BiPAP and she becomes hypoxic, and we've maxed
10 out on the BiPAP settings, and we have nowhere to
11 go. And she's going to be hypoxic and starting to
12 get -- you know, stay in a hypoxic state, as in
13 her oxygen saturations are going to be below 90,
14 below 88, you know, you know, in a situation where
15 the tissues are going to be devoid, slowly getting
16 more and more devoid of oxygen and will start
17 shutting down.

18 And in that scenario, we talked
19 about two options. One was intubate. That's the
20 next step, you know, and the second option was
21 don't intubate. And then if you don't intubate,
22 you're kind of in a situation where, you know, is
23 she going to be in this prolonged hypoxic stage
24 and then get better, or is she going to be in this
25 prolonged hypoxic stage and then start suffering

1 because she's on BiPAP to keep her going.

2 And then we introduced -- or I
3 introduced the concept of, you know, again,
4 because in the context of the conversation we want
5 to be optimistic, we didn't really want to go down
6 that path yet even though it was relevant.

7 I introduced that we could have a
8 comfort care conversation at that time, if we have
9 time. So she's prolonged hypoxic. It is
10 reflected in the note as well.

11 Q When you say "at that time," you mean at that
12 future time when that happens, not at the time of
13 the phone call?

14 A Correct, at the future time, if we had the
15 opportunity where she was hypoxic for a prolonged
16 amount of time, and we, you know -- we would have
17 to have a tough conversation to say should we
18 switch to comfort care. And that's a completely
19 different thing. That's now we're, you know,
20 switching to nasal cannula and we're letting her
21 pass peacefully with family at bedside because we
22 know that, you know, the inevitable is near.
23 And -- you know, but we weren't ready to have that
24 conversation. But I had to elicit the actual
25 scenario. I mean, obviously, if she's on BiPAP

1 max settings, not getting better, she could --
2 that potentially could happen.

3 And then after that we had a
4 conversation about worst case scenario, which was
5 the crashing, if she actually crashed. And in
6 that case I need to know -- I mean, to be honest,
7 every patient in the hospital needs to have a code
8 status. We need to know what people want.

9 Q Sure.

10 A Because the staff can't take the time, call a
11 family member in the event and figure out what
12 they want at the time. Plus, the family's usually
13 emotional, so they make irrational decisions or
14 they don't make it in a clear, thought, logical
15 way when you can have the conversation before. So
16 it's always addressed, has to be addressed. And
17 multiple providers, I believe, tried to address it
18 and weren't able to. So the lead into this
19 conversation was -- the end part was the code
20 status.

21 Q I think I know your answer to this, but it's kind
22 of been mixed into different things.

23 Was it your position in regard to
24 Grace's care at this time that absent intubation
25 CPR compressions would have been futile?

1 A Absolutely futile. In her situation they would
2 not have helped anything.

3 Q And what do you -- why do you say it? Why are you
4 so certain?

5 A CPR, resuscitating the heart is not an absolute
6 thing. Okay? You have like a 23 percent chance
7 of resuscitating someone's heart in the hospital.
8 It's not that high. And people think, you know,
9 you get CPR and you get your heart resuscitated.
10 It's ugly. A lot of compression, you know, causes
11 damage to the chest, rib fractures. All these
12 things. It's not what you see on TV. I'm just
13 going to throw that out there. That's if someone
14 has a reversible cause, their heart stops, but
15 hey, you can fix the underlying problem and you
16 can resuscitate the heart.

17 In people who have irreversible
18 causes and they're unable to -- we're not able to
19 fix that, what ends up happening is if you do CPR,
20 if you happen to, you know, get their heart
21 started, which is much less chance if your -- you
22 know, if you're tissue hypoxic, as in Grace's case
23 with tissue hypoxia and malnutrition and been on
24 BiPAP and under stress and all these things for
25 days. Okay? The chance of resuscitation is very

1 low, less than 23 percent, I can comfortably say,
2 much less.

3 And then what ends up happening if
4 you have an irreversible cause, the heart just
5 stops again. And so you end up just doing this
6 vicious cycle of compressions and trauma to this
7 person, and that's the end of their life; trauma,
8 trauma, trauma. You know, it's irreversible -- if
9 there's an irreversible cause, which was in her
10 case, I couldn't fix her in a day. Compressions
11 are futile.

12 And that's what I explained to
13 Scott as well, that in the events where you're
14 having respiratory failure, respiratory arrest
15 leading to cardiac arrest, it's not the heart that
16 stopped by itself, it was because of an underlying
17 respiratory -- you can't fix it. The
18 compression's not going to help. It's going to be
19 a futile effort.

20 Q Got it. I'm going to go to another document, if
21 you're okay?

22 A Okay.

23 MR. GUSE: At some point soon we
24 probably should take another break. It's been
25 about another hour and a half.

1 MR. PFLEIDERER: Sure, as long as -- I
2 mean, I'm trying to keep moving, but if you need a
3 break, that's fine.

4 MR. GUSE: Yeah, I mean I guess I need
5 to know from a time standpoint what time you want
6 to wrap up today.

7 MR. PFLEIDERER: I mean --

8 MR. GUSE: How long are you guys willing
9 to go?

10 MR. EDMINISTER: Let's confer on that
11 during a break and get back to you.

12 MR. GUSE: Okay. Sounds good.

13 MR. EDMINISTER: Okay.

14 VIDEOGRAPHER: We are going off the
15 record at 4:00 p.m.

16 (Brief recess taken from 4:00 p.m. to
17 4:23 p.m.)

18 VIDEOGRAPHER: We are going back on the
19 record at 4:23 p.m.

20 BY MR. PFLEIDERER:

21 Q All right. Dr. Shokar, earlier in the deposition
22 I handed you Exhibit 73. Do you have that in
23 front of you?

24 **A I do.**

25 Q Do you see the 73 at the bottom right?

1 **A** **Yes.**

2 **Q** Okay. This note purports to be authored by you.
3 Do you recognize this note?

4 **A** **I do.**

5 **Q** Did you author this note?

6 **A** **I did.**

7 **Q** Does this note appear to be a true and accurate
8 representation of the note that you authored?

9 MR. BIRNBAUM: And John, the Bates label
10 on that one?

11 MR. PFLEIDERER: It is Ascension 00033.

12 MR. BIRNBAUM: Gotcha. Thank you.

13 **A** **Yes.**

14 BY MR. PFLEIDERER:

15 **Q** Okay. The date of service on this note is
16 October 13th, 2021.

17 Do the notes in this document
18 relate to Grace's condition on October 13th, 2021?

19 **A** **Yes.**

20 **Q** The time of dictation of this note appearing on
21 Page 2 appears to be 1257 hours or just before
22 1:00 p.m.

23 Do the notes in this document
24 relate to Grace's condition just before that time?

25 **A** **Yes.**

1 Q Up there at the top under the Subjective, first
2 sentence is, "The patient was doing well on same
3 settings of BiPAP this a.m. of 20 over 15 at
4 100 percent FiO2."

5 Is that your recollection that
6 Grace was doing well on those settings that
7 morning?

8 **A She was stable, yes.**

9 Q You continue, "She was unable to wean to
10 90 percent as she does desaturate to about 80s.
11 She had an episode when she got agitated after
12 being assisted to stool and her Precedex was
13 increased to help control agitation as she is
14 starting to pull out a PICC and remove the mask."

15 Are those sentences, do they match
16 your recollection of events that morning?

17 **A Yes.**

18 Q And you say "Precedex was increased."

19 Was that your decision to increase
20 the Precedex?

21 **A It was not.**

22 Q Okay. Whose decision was that?

23 **A The Precedex order is ordered by the ICU**
24 **attending, ICU consultant, as an order that can be**
25 **carried out by nursing based off of their clinical**

1 **assessment. And so that's why actually she's in**
2 **the ICU and why that medicine's used in the ICU,**
3 **so that it can be titrated.**

4 Q And you said the ICU physician is the one that
5 ordered the Precedex in this case?

6 A **The -- as far as I -- as far as I know, I didn't**
7 **place the order. Usually it's placed by an ICU**
8 **attending. I'm not sure which one.**

9 Q Was Dr. Marada, was he the attending ICU
10 physician?

11 A **Not on the day that I was working.**

12 Q Either day, the 12th or the 13th of October?

13 A **I believe it was Dr. Gandev. That's who I**
14 **interacted with.**

15 Q You said that the ICU nurse is able to operate
16 within her or his discretion to increase the
17 dosage of Precedex; is that correct?

18 MR. GUSE: Objection. Misstates his
19 testimony. You can answer.

20 A **Generally, the ICU nurse is trained in the ICU.**
21 **It's in their scope to carry out the orders. If**
22 **they're on a drip that's titratable, they have the**
23 **ability to titrate that dose.**

24 BY MR. PFLEIDERER:

25 Q Up or down?

1 **A** **Up or down, yes.**

2 **Q** Okay. Is there --

3 **A** **Usually with up, you -- you know, notify somebody**
4 **that you had to do so; in that case the person or**
5 **the team that had ordered it.**

6 **Q** Is there a limit to how high a nurse can increase
7 the titration of Precedex in the ICU?

8 MR. GUSE: Object to form, foundation.

9 MR. PFLEIDERER: Yeah, I'll ask another
10 question.

11 MR. GUSE: Improper hypothetical.

12 BY MR. PFLEIDERER:

13 **Q** Yep. In regard to the order for Precedex that
14 Grace was -- that was involved with Grace's care,
15 was there -- do you know if there was a limit to
16 how high a nurse could increase the titration of
17 that Precedex?

18 **A** **I'm not --**

19 MR. GUSE: Hold on. Just -- are you
20 talking in general limit, or are you talking
21 specific to Grace's --

22 MR. PFLEIDERER: I'm talking about
23 specific to Grace's care.

24 MR. GUSE: Okay. I'm going to object.
25 I'm going to insert the Alt privilege. To the

1 extent that he may have been involved in that, he
2 can answer, but to the extent that that limit was
3 set, if such a limit was set by another provider,
4 I'm going to instruct him not to answer.

5 VIDEOGRAPHER: Is your mic on, Mr. Guse?

6 MR. PFLEIDERER: I'm not asking about
7 the standard of care. I'm just asking whether
8 there was a limit set.

9 MR. GUSE: I stand by the objection.
10 Because even asking in that form is really a
11 backdoor way of getting at standard of care, and
12 so I'm going to maintain my objection and maintain
13 my instruction if he -- not to answer.

14 If he was involved in setting the
15 limit or he made a decision setting the limit or
16 determining the limit, he can answer that. But to
17 the extent it was done by another medical
18 provider, I am instructing Dr. Shokar not to
19 answer.

20 BY MR. PFLEIDERER:

21 Q Okay. So I just want to make sure my question is
22 clear for the record here.

23 Are you aware of a limit being set
24 on that order?

25 **A Can I answer that?**

1 MR. GUSE: You can answer as to whether
2 you're aware there was or not.

3 **A I was not aware.**

4 BY MR. PFLEIDERER:

5 Q Okay. So am I understanding correctly that a
6 nurse under that order could titrate the Precedex
7 up as far as they deem necessary?

8 MR. GUSE: Again, are you talking
9 specific to Grace's case, or are you talking --

10 MR. PFLEIDERER: I'm talking about the
11 order, the order, the Precedex order.

12 **A Um, I don't know how to answer that. I'm not**
13 **aware of the titration capabilities of that order.**
14 **So I am aware that nurses can titrate based off of**
15 **a -- based off of the instructions of an order or**
16 **an ICU attending.**

17 BY MR. PFLEIDERER:

18 Q You say in your note that Precedex was increased.

19 Did somebody notify you that
20 Precedex was increased?

21 **A Nursing.**

22 Q Okay. Do you remember who?

23 **A The nurse in charge of that case on that day was**
24 **Ms. McInnis.**

25 Q And she's the one that notified you?

1 **A** **I believe so, but I -- it could have been one of**
2 **her colleagues.**

3 **Q** Still looking at the Subjective. You said -- I'm
4 on the fifth line, end of the fifth line, "She
5 required restraints by the time of the interview
6 with the goal to remove the restraints as soon as
7 possible."

8 Do you see that?

9 **A** **I do.**

10 **Q** Is it your recollection as you sit here today that
11 Grace did require restraints by the time of the
12 interview?

13 **A** **Yes. She was in restraints at the time of the**
14 **interview, soft restraints to her wrists.**

15 **Q** Do you know why she was placed in those
16 restraints?

17 MR. GUSE: Object to form, foundation.
18 You can answer if you know.

19 **A** **My nursing report had indicated, as I had written,**
20 **that she was more agitated. They had to increase**
21 **the Precedex, and to prevent her from pulling off**
22 **the BiPAP and her PICC line, which she was**
23 **grabbing at, they had to place her in temporary**
24 **soft restraints.**

25 When I ended up seeing her was when

1 I found out this information as well, you know,
2 clarified the information with the nursing
3 because, obviously, I'm visually seeing that she's
4 in restraints as well. Generally when restraints
5 are placed, we try to remove restraints as soon as
6 possible.

7 BY MR. PFLEIDERER:

8 Q Did anyone, to your knowledge, notify the family
9 that Grace had been placed in restraints, any
10 member of the family?

11 MR. FRANCKOWIAK: Objection.
12 Foundation.

13 MR. GUSE: Join.

14 A I'm not aware.

15 BY MR. PFLEIDERER:

16 Q Okay. Do you know if anyone attempted to notify
17 either Scott Schara, Cindy Schara or Jessica
18 Vander Heiden that Grace had been placed in
19 restraints?

20 MR. GUSE: Objection. Asked and
21 answered.

22 MR. PFLEIDERER: I asked if he knew if
23 anybody had successfully notified, not attempted
24 to. You can answer.

25 A I'm not aware.

1 BY MR. PFLEIDERER:

2 Q Okay. In your experience at St. Elizabeth
3 Hospital was it -- was it policy to notify the
4 decision-maker or the patient's family that the
5 patient had been placed in restraints?

6 MR. FRANCKOWIAK: Objection.
7 Foundation.

8 MR. BIRNBAUM: Object to form and
9 foundation.

10 MR. GUSE: Join.

11 MR. PFLEIDERER: You can answer.

12 A It -- I would have to -- I don't know the
13 actual -- I don't recall an actual policy, but
14 it's generally a good idea. You know, it's
15 generally followed through that we would give that
16 information. As far as the policy for timing and
17 if it's absolutely, you know, written in there,
18 I'm not aware.

19 BY MR. PFLEIDERER:

20 Q Okay. And why would it be a good idea?

21 A I mean, just in good communication with the
22 family, you should notify if you have someone
23 making the decisions for a patient who's -- you
24 know, they should be aware that that kind of
25 intervention was necessary.

1 Q Did you discuss these restraints on the morning of
2 October 13th with Nurse Hollee McInnis?

3 **A Yes.**

4 Q And what do you remember from that discussion with
5 Hollee McInnis?

6 **A Let's get her out of restraints as quick as**
7 **possible, you know. But that's easy to say,**
8 **harder to do. It really depends on, you know,**
9 **intervaed reassessments to determine when is the**
10 **safe and appropriate time to do so. And the**
11 **prerequisite for that would be, you know, having**
12 **her not pulling at lines or less agitated to do**
13 **so. So it's usually done in a trial fashion.**

14 Q Did you say to Hollee McInnis that the family was
15 not going to like it when they found out that
16 Grace had been put into restraints?

17 **A I don't recall that, but I mean, I could imagine**
18 **me saying that, because I don't think they would.**
19 **I wouldn't.**

20 Q Did you have any conversations with Dr. Gandev,
21 the Dr. Gandev that you had mentioned prior, did
22 you have any conversations with Dr. Gandev
23 regarding Grace's care on October 13th?

24 **A After I had a conversation with Scott in the**
25 **morning and changed the order in the computer and**

1 doing that assessment, I did run into Dr. Gandev
2 on the ICU ward. And I had informed him of the
3 conversation that I had in regards to the change
4 of code status, you know. And it was a relatively
5 limited conversation, I would say. And that was
6 roughly -- and he had mentioned, thank you, you
7 know, thank you for taking the time to have that
8 conversation, and that essentially, you know, if
9 it's -- it's -- you know, it would be a good idea
10 to just make sure that -- you know, if that's --
11 if that's the course that they wanted to go for,
12 you know, might be the best course after all, is
13 basically the paraphrasing of what he had said.
14 But again, a brief conversation.

15 Q Just to be clear, you said you had that
16 conversation in the ICU ward. Was that not in
17 Grace's room?

18 A On the -- on the floor outside all the rooms of
19 the ICU, in front of the -- a little to the -- I
20 remember running into him, because I was walking
21 left off the ICU, and I ran into him walking
22 towards the ICU.

23 Q I think you're familiar with, from your testimony
24 today, with Grace's sister Jessica Schara?

25 A I had some interactions with her, yes.

1 Q Do you have any knowledge of Jessica being sent
2 home to shower on the morning of October 13th?

3 A In review, along this review pathway, I learned
4 that, but at the time, no.

5 Q What do you mean by this review pathway?

6 A I learned after the fact, after the day that, you
7 know, that nursing was helping Grace, I believe,
8 to go to the bathroom, and that that's the time
9 where she was getting agitated and the Precedex
10 was increased at that point. And I learned this
11 because it was -- that family had gone -- Jessica
12 at that time had gone, you know, had stepped out
13 of the room. I didn't know the particulars at
14 that time that she had gone home to shower.

15 Q Do you understand or do you have any knowledge
16 that Jessica was told to go home by nursing staff
17 to shower?

18 A No.

19 Q Okay. You don't know whether she left on her own
20 volition or because she was asked by nursing
21 staff?

22 A Yeah, correct. I assume that she -- she had to
23 step out and was going to return.

24 Q And earlier when you said that somebody had helped
25 Grace go to the bathroom, you don't mean literally

1 go to the bathroom? You mean she defecated in the
2 bed?

3 MR. GUSE: Objection. Foundation.

4 MR. FRANCKOWIAK: And form.

5 **A No. I'm not sure, to be honest. I think they**
6 **were trying to assist her to stool, as far as --**
7 **and I don't know if that was in the bed or to the**
8 **bathroom, to be honest.**

9 BY MR. PFLEIDERER:

10 Q You have no knowledge?

11 **A I don't have knowledge, yes.**

12 **Probably makes sense for it to be**
13 **in the bed just given her status, but I don't want**
14 **to discount the fact that she tried to get to the**
15 **bathroom. I'm not really sure.**

16 Q I'm looking at the -- I'm back to 73, Exhibit 73,
17 looking at the second paragraph of the Subjective.
18 It says, "I had a discussion with the family over
19 the phone for roughly half an hour to an hour in"
20 regard to -- or sorry, "in regards to code status
21 once again as well as feeding options they have."

22 Do you remember this discussion
23 with the family?

24 **A Yes, I did. It was actually with just Scott,**
25 **actually.**

1 Q Just Scott?

2 A Yes.

3 Q And do you know where you were during this
4 discussion?

5 A I was in front of the nursing station. I was
6 sitting at the nursing station in front of Grace's
7 room in the ICU.

8 Q Were any other medical providers participating on
9 this call with you?

10 A No.

11 Q Either based on your recollection or anything in
12 this note, do you remember when that call would
13 have occurred?

14 A It happened just before I placed the DNI/DNR
15 order. If you look at that timestamp, it would be
16 right before that, for the hour preceding.

17 Q When you say just before that, do you mean -- you
18 said a half an hour preceding?

19 A I was on the phone for half an hour to an hour, so
20 it was -- after I got off the phone, that's when I
21 placed the order, and I believe that would have
22 been timestamped. I don't know when I dictated,
23 if it was immediately after or it was like half an
24 hour or an hour after.

25 Q I understand.

1 **A It was late morning is the best I can give you.**

2 **Yeah.**

3 **Q I'm on the fourth line of the second paragraph.**

4 It says, "We did discuss in regards to CPR
5 resuscitation and the futility of doing CPR in the
6 situation in regards to DNI, and they agreed in
7 regards to not pursuing a resuscitation via CPR or
8 defibrillation in the event of respiratory arrest
9 leading to a cardiac arrest."

10 Is that accurate to your
11 recollection?

12 **A Yes, mostly. Respiratory arrest, respiratory**
13 **distress used interchangeably.**

14 **Q Okay. You say, "In all regard, they want to**
15 **continue full management without intubation."**

16 What is meant by full management?

17 **A The agreement after that conversation was in the**
18 **effort to kind of have Grace survive, was that we**
19 **were going to continue with the BiPAP therapy as**
20 **long as possible, as long as possible. Because --**
21 **in the hope of optimism and hope, and we wanted to**
22 **see if she would pull through. So that's what**
23 **that means. The full management means continuing**
24 **what we're doing right now.**

25 **Q What -- we'll get there later.**

1 **A** **Remember if I --**

2 MR. GUSE: There's no question pending,
3 Doctor.

4 **A** **Okay. I was just going to clarify because I was**
5 **rereading.**

6 BY MR. PFLEIDERER:

7 Q You can clarify, please.

8 **A** **It was -- if you remember when I was talking about**
9 **the scenario where somebody was hypoxic for a**
10 **prolonged amount of time --**

11 Q Um-hum, I do.

12 **A** **-- right? Then we'd have to make a decision as**
13 **far as intubate or not intubate.**

14 Q Yeah. Sort of the same thing in this
15 conversation?

16 **A** **Correct, yeah.**

17 Q I'm starting a sentence here beginning with, "If
18 there is deterioration" -- do you see that?

19 **A** **Um-hmm.**

20 Q Okay. It says, "If there is a deterioration and
21 hypoxia without reversibility for a prolonged
22 amount of time, we may consider at that time
23 switching to comfort care after a discussion has
24 been completed with family to see if that is the
25 right time."

1 I know I asked you this before in
2 regard to the other note.

3 But if you did switch to comfort
4 care, I mean, what does that look like? Is that a
5 different set of medication? Is that bringing all
6 the family in? As you meant it in this note, what
7 did you mean by that?

8 **A It was a reflection of a scenario in which someone**
9 **who's on BiPAP therapy with an irreversible injury**
10 **and hypoxic for a prolonged amount of time, as I'd**
11 **written --**

12 **Q Um-hmm, yep.**

13 **A -- and we had the time to reconvene with the**
14 **family and have an appropriate comfort care**
15 **conversation about is this the time, you know, to**
16 **let her go, essentially.**

17 **And comfort care is basically a**
18 **switching of the understanding that we're going to**
19 **go away from full medical care to search and**
20 **cure -- you know, and pursue a cure and a**
21 **restoration, you know, and we're switching that to**
22 **an understanding that there is no cure or**
23 **restoration and she has -- she's going to**
24 **imminently die in the hospital in the next, you**
25 **know, few days.**

1 And in that regard we prepare the
2 family, prepare the patient, if they're able to be
3 prepared, and we remove any interventions that are
4 causes of suffering. In this instance, it would
5 have been the high pressure BiPAP. We would have
6 placed her on a high flow nasal cannula, which
7 would not have supported her oxygenations in the
8 least, and then she would have drifted off with
9 the aid of any type of palliative medications to
10 take away air hunger or any type of distress so
11 that she could pass peacefully, you know, with
12 family at bedside.

13 Q And what sort or -- what sort of palliative
14 medications are you referring to?

15 A Generally palliative care physicians -- or in
16 comfort care there's a comfort care order-set that
17 is initiated. That comfort care order-set
18 incorporates medications, you know, of a bunch of
19 different symptoms that could be distressing; one
20 being pain. So there'll be opiate medications for
21 pain. One being anxiety, so there's usually
22 benzodiazepines on that order-set. One is -- you
23 know, for diarrhea, they would have Imodium. One
24 is for constipation if it's distressing, have
25 laxatives. They would have for secretions,

1 scopolamine patch. You know, so a variety of
2 palliative medications set as p.r.n. to be given
3 by nursing, you know, in the event, when they're
4 doing their assessment that they feel that the
5 patient is in distress.

6 Again, we've -- it was in the
7 context where you have already determined that the
8 goal now is to remove any suffering to allow the
9 patient to pass peacefully. That is what comfort
10 care in the hospital is. And if you have time,
11 that is -- we usually discharge to, you know, home
12 with hospice, which does kind of the same thing.
13 But in the event some of those patients can't be
14 discharged home because they're imminently dying
15 or unstable to transfer, then we do that in the
16 hospital under -- under comfort care.

17 Q And you mentioned that opiate medications would be
18 used to sort of deal with the pain aspect of those
19 different considerations and comfort care.

20 A It's used in two different ways, actually. It's
21 used -- and for pain, it's a general
22 consideration, but it's also used for air hunger
23 and dyspnea, which is people -- that feeling of
24 shortness of breath. It's often used in patients
25 who have respiratory illnesses, COPD, end-stage

1 COPD, those kind of things where the route reason
2 someone is going to pass is from their -- from not
3 being able to breathe. So it will take away that
4 feeling of I can't breathe and gasping.

5 Q Um-hmm. And when the doctor puts -- you mentioned
6 a p.r.n. order, and I just want to clarify what
7 that is. A p.r.n. order is essentially an
8 as-needed order?

9 A Correct. It's not -- it's not a medication that's
10 given at a scheduled time. It's an order that's
11 given, you know, if on request, or offered if the
12 person, like a nurse would, or a doctor, feels
13 that it would be useful for that time.

14 Q And if I had an order that was p.r.n. to be
15 administered at most every four hours, how would
16 that be designated in the medical chart?

17 A You'd have the medicine, you'd have the dosing,
18 and then you'd have the schedule -- p.r.n.
19 schedule, such as Q4 p.r.n. or every four hours as
20 needed.

21 Q And a Q4 designates every four hours?

22 A Correct. So if you give it -- you're unable to
23 give it again for four hours unless you have an
24 authorization to give it again.

25 Q Got it.

1 MR. PFLEIDERER: I thought you were
2 about to lay a big objection on me.

3 MR. POJE: No. That's for later.

4 BY MR. PFLEIDERER:

5 Q Under your care, was Grace ever transitioned to a
6 comfort care sort of medical plan or plan of care?

7 A She was not.

8 Q Okay. At the bottom of the Subjective -- are you
9 with me? I'm on the 73.

10 A Um-hmm.

11 Q Right above the Objective.

12 A Yes.

13 Q It says, the patient -- "The patient was seen and
14 examined at bedside today."

15 Would that examination have been
16 done shortly before this dictation?

17 A Yes.

18 Q Okay. And by shortly I mean, for example, within
19 half hour, 15 minutes?

20 A No.

21 Q Okay.

22 A I usually see the patients prior to talking with
23 family. So in this situation, I was talking with
24 family, I would have wanted to give them a
25 clinical update of Grace at that time, and

1 **therefore, I would have done my -- my round on her**
2 **prior to that.**

3 Q Got it. Do you remember if Grace's sister Jessica
4 was at bedside when you examined Grace on this --
5 that led to these notes here?

6 A **Yes. I documented that her sister was at bedside.**

7 Q Did you have any conversations with Jessica during
8 that examination?

9 A **Not in that -- not really that morning apart from**
10 **how was Grace doing for -- you know, I usually**
11 **tried to get the family members' input as far as**
12 **how they're feeling the family member is doing.**

13 Q Do you remember anything else about talking with
14 Jessica besides just how Grace was doing?

15 A **I had a conversation with her later on in the day**
16 **that was much more extensive. But at that time it**
17 **was mainly to get a -- subjective pieces of data**
18 **about how Grace was doing.**

19 Q Got it. Was Grace verbal at this time, at the
20 time of this examination?

21 A **She was not. She was never verbal for me.**

22 Q Never verbal. Do you remember Jessica asking you
23 any questions during this examination?

24 A **Not specific questions. Jessica did ask**
25 **questions. They were mainly just in like general**

1 questions, nothing specific. And -- and I can't
2 recall specifics about any question because it was
3 just kind of in the regular discourse of
4 explaining what I was observing. But I can't
5 recall exact specific questions.

6 Q And did you observe anything that would indicate
7 that Grace was nonverbal either because of her
8 respiratory condition, or was it because of the
9 sedation, or either, or both, or neither?

10 A It's hard for me to answer, because the day
11 preceding and the day of that you're -- that we're
12 questioning were the only two days that I had to
13 experience Grace. And both days were -- were
14 similar in regards to her, you know, presentation
15 to me in the morning, which was someone who's
16 nonverbal, had a BiPAP mask on, was, you know,
17 able to move and that kind of thing but seemed
18 mildly agitated on this particular day versus the
19 day before where she was calm. But overall, you
20 know, it was -- I don't really have -- I can't
21 allude to was it because of this or that.

22 Q That's fine. Yeah, I don't want you to speculate.
23 Under -- I'm looking at the
24 Objective now, vital signs. Are you with me?

25 A Yes.

1 Q I see a temperature of 101.4. I can't remember
2 the number that you gave earlier in your
3 deposition, but I believe that is considered a
4 fever; is that correct?

5 **A Yes.**

6 Q Okay. And you don't have any reason to dispute
7 that temperature reading, do you?

8 **A I do not.**

9 Q Okay. I'm looking at the Plan section on Page 2,
10 No. 3.

11 Are you with me? Under Plan.

12 **A Yes.**

13 Q Says "Requiring Precedex increased rate to 1.4 due
14 to significant agitation this a.m. with goals to
15 wean back down."

16 Did I read that correctly?

17 **A Yes.**

18 Q What is the significant agitation that you were
19 referring to in this note?

20 **A That was the reported agitation from the nursing
21 report that I verbally received that morning that
22 indicated that she was having a lot of distress in
23 the early hours of the morning where she was
24 unable to prone anymore, you know, for a prolonged
25 amount of time.**

1 And the event in regards to the,
2 you know, the stooling event where she got really
3 agitated as well. So that is all recorded as a
4 reflection of why the Precedex was increased, and
5 I had it in my plan as under the, you know,
6 medication that she was on and why it was at 1.4.

7 Q At the time of the examination that led to the
8 creation of these notes, did you think that it was
9 likely that Grace would die in the next day or
10 two?

11 A I had my concerns, yes.

12 Q That's a yes?

13 A Yes.

14 Q Okay. And did you ever inform either Grace's
15 sister Jessica or Scott or Cindy Schara that you
16 thought that it was likely that Grace would die in
17 the next day or two?

18 A Not in those words. I didn't directly say she's
19 going to die in the next day or two. Again, we
20 were in an air of optimism here. That was a very
21 sensitive topic to say that she's going to die.
22 She was still saturating -- you know, at the time
23 of this note, she was still saturating above 88,
24 90 percent, and we were still able to keep her
25 oxygenations there.

1 So I didn't have -- there was no
2 prompt at that time to directly say she was going
3 to pass away within 24 to 48 hours because she
4 wasn't hypoxic at that time. I also thought it
5 would not be received very well. But again, they
6 did know the severity -- I thought they did know
7 the severity of her situation given the data that
8 I was informing them of.

9 Q Is there anything that you did not tell Scott
10 Schara, Cindy Schara or Grace's sister Jessica
11 because you did not think that it would be
12 received well?

13 MR. GUSE: Object to the form of the
14 question. Vague and ambiguous.

15 MR. PFLEIDERER: That's fair. Let me
16 ask a better one.

17 BY MR. PFLEIDERER:

18 Q During the time that you were treating Grace at
19 St. Elizabeth, was there anything regarding
20 Grace's condition or medical care or treatment
21 that you did not tell the parents or the sister
22 about because you did not think it would be
23 received well?

24 A No.

25 MR. BIRNBAUM: Object to the form.

1 BY MR. PFLEIDERER:

2 Q You can answer.

3 A Said no. Your question preceding was about if I
4 directly told them that she was going to die in a
5 day or two, and that's not something I can
6 determine. You know, that's not something at that
7 time or through the hospitalization I can say. I
8 can say that there's a probability that she can
9 pass, but I don't have like a crystal ball to say
10 exactly when she's going to die or if it's going
11 to be in that time period. And I did not withhold
12 any information from them.

13 Again, the whole goal was to
14 provide as much information and transparency as
15 possible from my side. But within context.
16 Because by me saying she's going to die today
17 would have been a deterioration in the rapport and
18 communication going forward, because then I would
19 have been just like everybody else or whatever,
20 you know, considerations there may be.

21 So I had to, again, tread carefully
22 on giving them objective data and giving them as
23 much information as I could without ruining that
24 relationship or changing the care plan.

25 Q You are aware that Grace did die at St. Elizabeth

1 Hospital?

2 **A I'm aware.**

3 Q Did you ever communicate to the family that
4 Grace's death was imminent?

5 MR. GUSE: Object to the form of the
6 question.

7 MR. PFLEIDERER: I'm going to keep that
8 question.

9 MR. GUSE: Vague and ambiguous. Plus, I
10 also think it's been asked and answered.

11 MR. PFLEIDERER: You can answer.

12 **A I believe I've answered this multiple occasions.**
13 **I implored that she could die at any time. She**
14 **can crash today, she can crash overnight, she can**
15 **crash at any time. That infers the imminency of**
16 **her -- and the severity of her situation. I**
17 **inferred multiple times on how we were escalating**
18 **her BiPAP, you know, and on this particular day**
19 **how she's going through another inflammatory**
20 **situation with the elevated fever and her labs**
21 **looking a lot worse.**

22 So it's -- it's like I gave them
23 everything to come to a reasonable conclusion that
24 this is on the horizon as much as I could. I had
25 conversations that revolved around the fact that

1 like 5:50 p.m. when I was called to the room due
2 to the significant hypoxia that was going on. And
3 we can obviously get into that as well.

4 But essentially, that required my
5 attention over the next 40 minutes or so. What
6 had to do -- you know, she was hypoxic. The
7 interventions that I did during that time period
8 allowed her oxygenation to reach an appropriate
9 level again. When I left that room, her vitals
10 were what they were before and oxygenation was
11 95 percent.

12 So I reasonably thought that, hey,
13 she's going through an inflammatory crisis, but I
14 was able to stabilize her again by initiating, you
15 know, an adjustment to her care plan.

16 Then I called Scott right
17 afterwards and explained to him the events that
18 had preceded and that we were adding -- that
19 morphine was given to help stabilize her
20 respiratory situation, and that she was stable
21 when I left the room. Monitored her while I was
22 talking to him for 15 minutes. And then at that
23 time, you know, after discussing all that, then
24 left.

25 So there was not a moment to have

1 time pass enough where I could tell them that, oh,
2 this is it. It was a scary moment, and I was
3 hopeful that it was a -- a one-time event. But as
4 the pattern suggests, you know, she was having a
5 really tough time that day.

6 BY MR. PFLEIDERER:

7 Q So when you left, I can't remember the time, you
8 said you started in the room at 5:50 in Grace's
9 room, 5:50 p.m. approximately?

10 A Approximately. It was like quarter to 6:00-ish,
11 yeah.

12 Q And about how long do you think that you were in
13 the room?

14 A I was in the room for a good 15, 20 minutes, and
15 then out of the room and talking to Scott for
16 another 15, 20 minutes, which would place me
17 around 6:30-ish or so. And around that time I had
18 left the unit.

19 Q And at that time you thought that Grace had been
20 stabilized?

21 A For that event, yeah. Yeah. She was not -- she
22 was somebody who was, again, on high levels of
23 BiPAP, in a very critical situation. Family was
24 aware of the critical situation. We've had
25 multiple discussions. That was kind of the next

1 **thing in the line of, you know, what she faced,**
2 **and we were able to get through it at that time.**

3 MR. PFLEIDERER: We're going to be able
4 to do it, Randy.

5 MR. GUSE: I'm counting on you.

6 MR. PFLEIDERER: It's going to happen.

7 BY MR. PFLEIDERER:

8 Q I'm under Plan, No. 6. I'm going to read it.
9 "Goal of activity is to have her in a chair
10 watching television."

11 Did I read that correctly? Do you
12 want me to read the rest of it?

13 **A Yeah, because it looks like there was a break in**
14 **the sentence.**

15 Q Are you referring to the period at the end of that
16 sentence, or what do you mean?

17 **A Correct.**

18 Q Do you want me to read the whole thing?

19 **A The period -- the sentence should incorporate the**
20 **next sentence, because it hangs.**

21 Q Okay, sure. Yeah, that's fine.

22 "Goal of activity is to have her in
23 a chair watching television if she is lightly
24 sedated as related by the family."

25 Are you saying the period should

1 not be there?

2 **A Correct.**

3 Q I see. Was this your goal of -- having her in the
4 chair watching television, was that your goal at
5 this time?

6 **A Not at that immediate time, but it was in**
7 **discussion with Scott where -- where, again, in**
8 **the air of trying to visualize a, you know, an**
9 **ideal resolution or a recovery for Grace. Some of**
10 **the concerns was that we were, you know, sedating**
11 **her too much and, you know, she's not moving,**
12 **she's in the bed all day long, you know, and if we**
13 **really wanted her to recover, you know, she likes**
14 **watching TV, let's get her in a chair, let's**
15 **lightly sedate her. So those are concerns brought**
16 **up by Scott.**

17 The sentence that was written down
18 was a reflection of, you know, of the goals of
19 care -- of what he wanted for her, for Grace,
20 which was reducing sedation, if we can, getting
21 her into a chair, getting her watching television,
22 those things would perk up her mood, and, you
23 know, she would be in a better position to
24 recover.

25 Q So Section 8 under Plan, you state, "Code status

1 was reviewed with family and she is a DNR/DNI."

2 Do you see that?

3 **A I do.**

4 Q Did I read that correctly? Did I read it
5 correctly?

6 **A Yes, you did.**

7 Q Okay. Does your statement here that says she is a
8 DNR/DNI, does it conflict with your statement in
9 the Subjective that says "they want to continue
10 full management without intubation"?

11 **A No.**

12 Q Okay. Is that because in this case a DNR had the
13 same practical effect as a DNI?

14 **A No. It conflicts because the statement in the
15 Subjective is in referring to continuing --**

16 Q Sorry, doesn't or does conflict?

17 **A It does conflict -- what did I say?**

18 Q You said it does conflict. I'm asking you if your
19 statement under No. 8 in Plan conflicts with your
20 statement in the Subjective that says "they want
21 to continue full management."

22 **A It doesn't conflict because they're two different
23 things.**

24 Q Okay. Does -- does full management -- or sorry.
25 Strike that.

1 Does DNI as a code status, does
2 that still permit reversal of an opiate
3 over-sedation?

4 **A Yes.**

5 Q Does it still permit reversal of Precedex
6 over-sedation?

7 **A Yes.**

8 Q Okay. At this time, at the time that you did the
9 examination that led to the creation of this note,
10 did you observe Grace to be in any pain?

11 **A Not pain. More distress.**

12 Q And what did you observe about her that made you
13 think that she was in distress?

14 **A I mean, she was having a tough time with the
15 BiPAP.**

16 Q Was she trying to remove the mask?

17 **A She was very fidgety. I mean, you could tell that
18 she was unhappy. You know, again, she wasn't
19 verbal to me, but I could just from her body
20 language, she just felt very annoyed and bothered
21 and just, like, had an overall agitation, moving
22 around, that kind of thing.**

23 Q Were you aware at the time you were treating Grace
24 that Grace had Down syndrome?

25 **A I was.**

1 Q Okay. In regard to your treatment of Grace, did
2 her diagnosis of Down syndrome, did that impact
3 your care in any way?

4 **A No.**

5 Q Okay. You didn't adjust any treatments or any
6 methods or modalities to account for Grace's Down
7 syndrome?

8 **A No, there's no need. She was a high-functioning**
9 **Down syndrome. She had no -- on review, she had**
10 **no, you know, altered anatomy or anything from**
11 **like a cardiac perspective or pulmonary**
12 **perspective, apart from obstructive sleep apnea,**
13 **which was the only thing that was in consideration**
14 **of her care. You know, we list those diagnoses**
15 **mainly to create an awareness that if there are**
16 **issues in association with Down syndrome that you**
17 **should be aware of them.**

18 Q Okay. We're going to go to the discharge summary.

19 **A Okay.**

20 Q I'm going to give it to you.

21 **A Thank you.**

22 Q Dr. Shokar, I just handed you what's been marked
23 as Exhibit 74. Do you see the 74 there on the
24 bottom right?

25 **A I do.**

1 Q This discharge summary purports to be authored by
2 you. Do you recognize this discharge summary?

3 **A I do.**

4 Q Did you author this discharge summary?

5 **A I did.**

6 Q Take a moment if you'd like, but my question is:
7 Does this discharge summary appear to be a true
8 and accurate representation of the discharge
9 summary that you authored?

10 **A (Witness reads.) Yes.**

11 Q The date of service on this discharge summary is
12 October 13th.

13 Does this document relate to
14 Grace's condition on October 13th, 2021?

15 **A Yes.**

16 Q And just to be fair, there are some comments in
17 this note about how Grace presented, and obviously
18 that did not happen on October 13th, correct?

19 **A Correct, yeah. This is a summary of the entire
20 hospitalization, which is what is generally
21 reported out on a death summary.**

22 Q This document reflects that you dictated this
23 discharge summary on October 17th at 2239 hours;
24 is that correct? Is that when you dictated this?

25 **A It must be, yeah.**

1 Q Okay. Is there any reason why -- or why would it
2 be four days later after the death? Why would you
3 have dictated it four days later?

4 A I thought about Grace's death -- let me rephrase.
5 You don't have to dictate a note right away,
6 essentially. I do that normally for progress
7 notes and H&Ps, because it needs to be in the
8 record for other staff to review, you know, so
9 that they can manage -- they know what's going on
10 and whatnot. When it comes to discharge summaries
11 or death summaries, I usually -- I don't dictate
12 those right away. Plus, I had to review, you
13 know, the rest of the chart, you know.

14 Q Sure.

15 A And then, you know -- so this becomes more of like
16 I'm not doing that right after she dies, you know.
17 I'm doing -- I was not -- I was not on service
18 either, so I didn't get the -- you know, I didn't
19 have the -- really the time to kind of just do it
20 right away. I had other duties as well.

21 Q That's fine. Approximately in the middle, if you
22 go down the left side, you'll see a line beginning
23 with "that" and then following that word.

24 Are you with me?

25 A Sorry. Where?

1 Q There's a sentence beginning, "There were multiple
2 discussions," but the beginning of that line has
3 the word "that." It's about halfway through the
4 paragraph.

5 **A Yes, yes, yes, yes.**

6 Q So there's a sentence there, it says, "There were
7 multiple discussions with family in regards to her
8 plan of care and considerations for goals of care
9 and worst case scenario."

10 Are there any conversations at the
11 time of Grace's care that you had with Grace's
12 family that we have not discussed today?

13 **A Let me think. One, two, three -- just the
14 conversation we had after the day of her passing.**

15 Q Okay. And what day was that?

16 **A That was on October 14th in the morning, I talked
17 to Scott by phone, again, probably about a half an
18 hour or so, kind of as a, you know, almost as a
19 debrief, really, to go over the events of the
20 preceding night.**

21 Q And we established that Grace died on the 13th.
22 You said this was the 14th?

23 **A Correct, yes. This was the day after when I got
24 in.**

25 Q And did you initiate that call or did Scott

1 initiate that call?

2 **A** Every communication in the morning through the
3 12th, 13 and 14, generally I would call, but Scott
4 would always beat me to the gun and actually
5 request a call.

6 **Q** Me too. He does that to me, too.

7 **A** Yeah. So he -- I could say he requested it, but
8 it was something that was going to be delivered to
9 him regardless.

10 **Q** But you did talk with him on the 14th?

11 **A** I did.

12 **Q** Did Scott ask you the question on the 14th whether
13 Grace's -- Grace would have lived if she was put
14 on a ventilator?

15 **A** I believe so.

16 **Q** Okay. And how did you answer that question?

17 **A** Um, to be honest, I don't recall the exact
18 specifics. What I went over, you know, was that
19 somebody who has been on BiPAP for, you know, a
20 few days and is developing fibrosis in the lungs
21 as seen on her imaging, and has COVID, has a very
22 poor prognosis of being -- you know, poor
23 prognosis surviving intubation. It's generally
24 understood about 10 to 20 percent or so.

25 Again, that was -- I don't know

1 confound -- 'cause I don't know if I talked to
2 him -- I talked to him about that on the 13th.
3 I'm not sure if I talked to him on the 14th.

4 Q Okay. But it could have been either day?

5 A One of the days, yes. It was definitely the 13th,
6 because I had that conversation about -- very
7 extensive about intubation -- let me rephrase.

8 I talked to him on the 12th about
9 intubation and everything that it pertained
10 inclusive of, you know, the chance of recovery
11 from a COVID patient, the need for tracheostomy if
12 you're going to be intubated after about seven to
13 ten days, the need for a PEG tube, all that was
14 discussed so that he can make an informed
15 decision.

16 The 13th conversation established
17 right away that, you know, they convened as a
18 family and wanted definitely to be DNI, and then
19 on questioning afterwards about DNR, he needed me
20 to review that again, and so which we did.

21 And then on the 14th, he asked
22 mostly, as far as what I recall, about morph --
23 you know, did you have to give morphine, would
24 that have had any effect on, you know, her
25 passing. And that's honestly what I mostly -- it

1 was a shock. You know, he -- I was trying to --
2 he just suffered a loss. I wasn't -- I wasn't --
3 I was trying to give him answers to his questions
4 without imparting hurt.

5 Q Um-hmm. The fifth line from the bottom begins the
6 sentence, "Unfortunately, on October 13th" -- do
7 you see that?

8 A Yes.

9 Q Okay. It says, "Unfortunately, on October 13th,
10 2021 she," being Grace, "developed sudden and
11 significant hypotension and bradycardia after
12 being on high levels of BiPAP pressures for a few
13 days."

14 Is it your recollection as you sit
15 here today that she did develop sudden and
16 significant hypotension and bradycardia?

17 A That was what was reported to me that that's what
18 happened. It's a -- it's a way around saying she
19 had a cardiac arrest, because I couldn't confirm
20 myself she had a cardiac arrest.

21 Q Based on your treatment of Grace and your review
22 of the records, do you have any idea on why those
23 two conditions would suddenly develop?

24 A They -- they developed a bit -- remember when I
25 went into that room, she was having a little bit

1 of bradycardia and I turned off the Precedex at
2 that time to take away that as a confounding
3 factor. But this is a consequence of hypoxia.

4 If you have, you know -- eventually
5 if your tissues are hypoxic, you know, and you're
6 not getting nutrition, your body's going to shut
7 down and you end up suffering a cardiac event.
8 That's what's going to happen. It's inevitable --
9 it ended up being an inevitable outcome, unless
10 you had appropriate tissue oxygenation. So that's
11 how it looks. You don't -- I mean, people who
12 have respiratory issues, that's what ends up
13 happening, you have bradycardia and you get
14 hypotension.

15 Q In October of 2021 when you were treating Grace,
16 did you know what the half-life of Precedex was?

17 A Six minutes. I did know.

18 Q Six minutes?

19 A Um-hmm. That's why I turned it off right away and
20 waited.

21 Q While you were treating Grace in October of 2021,
22 was Dr. Beck involved in any way with Grace's care
23 to your knowledge?

24 MR. GUSE: Object to the form. Vague
25 and ambiguous as to time.

1 BY MR. PFLEIDERER:

2 Q Okay. While he was treating Grace.

3 A Dr. Beck's a nocturnist. He took over care at
4 7:00 for me on the 13th and the 12th, I believe,
5 because I think he was on that day, too. He works
6 7P to 7A -- I'm sorry, 6P to 6A. We switch off at
7 6 here, so he was on at 6, but I was still in the
8 hospital by, you know, like I said, 6:30 on the
9 13th, so I signed out to him when I got back after
10 I left the unit. Do you need me to clarify that?

11 Q Yeah, please. You just threw a couple times out.

12 A Sorry. I apologize. I'm confounding my new job.

13 Q No need to apologize. We're in a different time
14 zone.

15 A Yeah, we're on different -- the schedule here was
16 6:00 a.m. to 6P, and then the nocturnist comes in
17 6P to 6A. And so we have 24-hour coverage in the
18 hospital, but that's our shift times.

19 So I was here obviously till 6:30,
20 you know -- you know, dealing with that crisis.
21 When I eventually left the unit, I went back and
22 we started preparing our sign-out for doctor --
23 for the nocturnist. So he was involved in that
24 capacity where he covered over the night.

25 Q And you said that you left after the crisis at

1 approximately 6:30?

2 **A Yeah, I think it was around there. It was late.**

3 **Every night I was going -- the 12th and the 13th I**
4 **was home late.**

5 Q And you said at that point Dr. Beck took over care
6 for you?

7 **A Correct.**

8 Q Okay. Dr. Shokar -- whoops -- I'm going to hand
9 you what's been marked as Exhibit 75.

10 **A Yes.**

11 Q Okay. Did you get that piece of paper there?

12 **A Yes, I did.**

13 Q Is there a 75 there at the bottom?

14 **A Yes, there is.**

15 Q Okay. This is a record that I received from
16 Ascension Health. I'm not asking you to testify
17 as to its authenticity, but I am going to ask you
18 a couple questions about some things in this
19 document.

20 MR. BIRNBAUM: John, before you start,
21 could you give me the Bates number, please?

22 MR. PFLEIDERER: Yeah, sure. I've been
23 trying to do better about that, but I forget every
24 time. It's Ascension 01008.

25 MR. BIRNBAUM: Thank you.

1 BY MR. PFLEIDERER:

2 Q This document purports to be a record for an order
3 for morphine, and the time of the order here, just
4 have to find it -- oh. The time of the order
5 appears to be 1830 hours.

6 Is this, to the best of your
7 recollection, did you put the order in verbally
8 for morphine at 1830 hours?

9 A I don't know the time, but -- that seems a little
10 late, but it was at the -- it was -- doesn't it
11 say 1815 here? Is that not --

12 BY MR. PFLEIDERER:

13 Q That looks like the administration time. And what
14 I'm wondering is, you give a verbal order maybe to
15 Hollee McInnis, and then it doesn't actually --

16 A We were -- we were -- we were in like an event,
17 right?

18 Q You were --

19 A We were in the room together --

20 Q Yeah, yeah.

21 A -- trying to stabilize Grace. So she was helping
22 me. I gave the verbal. She got the med. She
23 administered the med. She probably recorded it
24 after, as far as what I'm assuming, because this
25 time may not be reflective of the actual time. It

1 **may have been prior.**

2 Q Yeah, and that makes sense to me.

3 Down there at the bottom it says --
4 there's a bold type there, it says "SIG" and then
5 next to that it says "p.r.n. Q4H"?

6 A **Um-hmm.**

7 Q Now, based on our discussion earlier, I interpret
8 that to mean an as-needed every four hours order;
9 is that correct?

10 A **Correct, yeah.**

11 Q Is that the type of order that you put in for
12 morphine at approximately 1815 or 1830 hours?

13 A **Yeah. Due to the success of the morphine
14 administration in improving her oxygenation and
15 the fact that we had turned off the Precedex, and
16 I didn't have many tools -- I mean, you only
17 have -- normally have two tools, Precedex, Ativan,
18 to help with agitation. Her respiratory rate was
19 60, went down to 40. There was a definite
20 improvement in her oxygenation as far as I could
21 see on three different monitors that were attached
22 to her. You know, so I felt that morphine was a
23 good medication that we could use in the future,
24 you know, to keep her -- you know, if she was
25 having this event happen again in regards to, you**

1 know, hypoxia from high respiratory rate, this
2 would be the medication that we could potentially
3 use to avert any further crises.

4 Q And just to be clear, you said that you turned off
5 the Precedex prior to your order for morphine; is
6 that correct?

7 A Correct. The first thing I did in the room after
8 my primary survey was notice that the heart rate
9 was lower than I would have liked. Knowing the
10 effects of Precedex and the consideration of other
11 modalities I could potentially use during that
12 time period, the first thing I needed to do was
13 remove Precedex. So that was initially
14 discontinued.

15 Then we did the -- you know, then I
16 was in there evaluating Grace for enough minutes
17 that would pass where I'd feel reasonably
18 confident that I could give another agent, which
19 would have been the morphine, if I needed to, and
20 determined that I did need to. I mean, she was
21 breathing incredibly fast. She didn't wake up
22 from not having Precedex or so. There's no other
23 medication I really could have given at that time,
24 apart from an opiate. And so I gave the lowest
25 dose I could, which is a 2-milligram dose under

1 what is normally given. But, you know, I gave
2 that to just wait and see what happens. And it
3 seemed like the 2-milligram dose, you know, was
4 sufficient enough to bring her respiratory rate
5 down from 60 to 40 and her oxygenation up. I
6 waited a bit. I went outside the room. I called
7 Scott and monitored her from, you know, outside
8 the room to see what, you know, what the effects
9 of the morphine, if it was going to persist.

10 And it seemed like she was doing
11 okay by the time I left the unit.

12 Q On that phone call you had with Scott, did you
13 tell Scott that Grace had had a good day?

14 A On that phone call?

15 Q Yes.

16 A I don't think so.

17 Q You don't think that you did say that, or you
18 don't recall?

19 A No. What I would have said is that she's stable
20 and that she's doing okay right now. I -- not
21 that she had a good day. She didn't have a good
22 day. We -- I called him prior to that indicating
23 that she didn't have a good day. She was on 20
24 over 15. She was stable from her -- in regards to
25 her oxygen saturations, whatnot, but she was in

1 febrile crisis. She had a fever and all that kind
2 of thing. So she -- that was all reported to him.
3 I said she was doing okay right now.

4 Q Sure. I get it.

5 A 'Cause, you know...

6 Q Was anybody else in the room with you when you
7 discontinued the Precedex?

8 A Yeah. Nurse McInnis was there. She's the one
9 that stopped it. She was in the room with me.
10 And Jessica was there, too.

11 Q Did you give a verbal order to Nurse McInnis in
12 that room to turn off the Precedex?

13 A Correct, yes, it was a verbal order.

14 Q And you said that was at approximately 5:45 p.m.?

15 A Yeah. I would -- I think so. It was like quarter
16 to 5:00-ish.

17 Q Quarter to 6:00?

18 A Quarter to 6:00-ish. Sorry. Yeah. Around there.
19 I don't know the specific time, to be honest,
20 because it was all -- everything is moving fast
21 when you're in those situations.

22 Q At any time -- at any time during your treatment
23 of Grace, did you ever consider transferring Grace
24 to another hospital?

25 A No.

1 Q Are you aware -- or I should say, or were you
2 aware in October of 2021 while treating Grace of
3 any synergetic effects of Precedex and morphine
4 being used together?

5 MR. GUSE: Object to the form of the
6 question. Vague and ambiguous. You can answer if
7 you understand the question.

8 **A I was aware.**

9 BY MR. PFLEIDERER:

10 Q Okay. And what were you aware of?

11 **A They are all CNS depressants.**

12 Q And what does that mean?

13 **A It means that Precedex, Ativan, morphine, these**
14 **class of medications are all essentially**
15 **depressants. And I was well aware that if you're**
16 **going to combine depressants, you should be a bit**
17 **careful, you know, about doing so. You don't just**
18 **do it right -- you know, without context. You do**
19 **it in -- if you need to, and you do it at a lower**
20 **dose, which is what I implemented.**

21 Q And that's because when there's too much of it, it
22 can depress the central nervous system too much?

23 **A Generally it's a dose-dependent issue. You know,**
24 **like, for instance, with morphine, it's usually**
25 **higher doses, accumulating doses.**

1 You mentioned Precedex earlier
2 regarding about time frame when morphine is used
3 in an accumulated dose over time, you know. So
4 you always want to -- you always want to keep that
5 in consideration. If you are going to add a
6 morphine derivative, you know, I didn't want to
7 add it to three things, so I stopped the Precedex
8 as fast as I could. But I had -- I was forced to
9 kind of give something to help the situation out,
10 and the only tool I had in the tool bag was
11 morphine. And again, knowing that she had already
12 had Ativan, too, I gave the lowest dose possible
13 and then monitored.

14 MR. PFLEIDERER: What time is it?

15 BY MR. PFLEIDERER:

16 Q Dr. Shokar, before I give this to you.

17 In October 2021 when you were
18 treating Grace, were you aware of the halflife of
19 morphine?

20 A I was.

21 Q Okay. And what was it?

22 A It's like about -- it's an estimate of the
23 duration being around three to four hours.

24 Q Three to four hours?

25 A Um-hmm.

1 Q I'm handing you what's been marked Exhibit 76.

2 Aaron, this is Ascension No. 00102
3 and the following four pages.

4 Sure. I guess before we get into
5 this, when you were treating Grace in October of
6 2021, Dr. Shokar, were you aware of the halflife
7 of Ativan or lorazepam?

8 **A Yes.**

9 Q Okay. And what was it?

10 **A That's a longer one. That's like, you know, 40**
11 **hours or so.**

12 Q Forty hours?

13 **A Yeah. It's longer.**

14 Q Dr. Shokar, this is a document that I received
15 from Ascension Health. It purports to be a
16 Medication Administration Summary for
17 dexmedetomidine. Did I say that right? Tomidine?

18 **A Sure. I mean Precedex. Yep.**

19 Q Precedex, yep. And as you flip through these
20 pages, you can see these purported administration
21 dates by various nurses at different times
22 including administrations on October 12th and
23 October 13th when you were treating Grace Schara.

24 And assuming this medication
25 administration is accurate now -- have you seen it

1 before?

2 **A No. Apart from my review from the documents that**
3 **Mr. Guse sent me.**

4 Q Assuming it is accurate, it does reflect an actual
5 order.

6 As Grace's treating physician,
7 would you have the authority to modify this order
8 for medication?

9 MR. GUSE: Object to the form of the
10 question.

11 **A Clarify.**

12 BY MR. PFLEIDERER:

13 Q As her physician, could you have set a limit on
14 the titration rate for Precedex?

15 MR. GUSE: Object to the form of the
16 question. Vague, ambiguous, incomplete
17 hypothetical.

18 BY MR. PFLEIDERER:

19 Q You can answer if you understand the question.

20 **A I don't touch Precedex. I don't titrate Precedex.**
21 **I stop it if I need to. I don't start and I don't**
22 **do titration orders for it. That's in the realm**
23 **of ICU.**

24 Q Okay. Did you ever bring up any concerns --
25 strike that.

1 During your treatment of Grace
2 Schara in October of 2021, did you ever raise any
3 concerns regarding the use of Precedex to Dr.
4 Gandev?

5 **A I did not.**

6 MR. PFLEIDERER: Take a quick break
7 here? Wrap it up, hopefully, after that.

8 MR. GUSE: Yeah, that sounds good.

9 VIDEOGRAPHER: We are going off the
10 record at 5:42 p.m.

11 (Brief recess taken from 5:42 p.m. to
12 5:53 p.m.)

13 VIDEOGRAPHER: We are going back on the
14 record at 5:53 p.m.

15 MR. PFLEIDERER: 77.

16 BY MR. PFLEIDERER:

17 Q Dr. Shokar, I'm handing you what's been marked as
18 Exhibit 77.

19 Are you familiar with a person
20 named Lorna Speid?

21 **A Not off the top of my mind. Who did you say it**
22 **was?**

23 Q Her name is Lorna Speid. Let me ask you a better
24 question.

25 Are you aware of anyone filing a

1 complaint against you with Wisconsin DSPS in the
2 past year or so?

3 **A Yes.**

4 Q Okay. And if I told you that person was -- or I'm
5 sorry. Has there been only one or has there been
6 more than one?

7 **A There has been two, the first being Scott a month
8 after, and then randomly more recently someone
9 filed for the same situation --**

10 Q And if I told you --

11 **A -- which is this one.**

12 Q -- that person was Lorna Speid, you would agree
13 with that?

14 **A Makes sense, yes.**

15 Q This is a document that we received from a public
16 records request to the state of Wisconsin.

17 Have you ever seen this document
18 before?

19 **A I did briefly review it before, I think.**

20 Q Before this deposition?

21 **A Yes.**

22 Q In preparation for this deposition?

23 **A No.**

24 Q Okay. Do you know if you reviewed this document
25 prior to it being --

1 MR. EDMINISTER: Submitted?

2 MR. PFLEIDERER: Well, let me strike
3 that.

4 BY MR. PFLEIDERER:

5 Q Do you know whether this document was submitted to
6 Wisconsin DSPS?

7 A I mean, I don't know that for a fact. I know that
8 it was sent to me prior to -- or along that
9 process of -- of the complaint, because Mr. Guse
10 was the one that was helping me out for that.

11 Q And you mentioned that you did review this
12 document. When you reviewed this document, did
13 you find that it was accurate? To the extent --

14 A I --

15 MR. GILL: Counsel, this is Gill. Can I
16 just impose an objection to form on the record?

17 MR. PFLEIDERER: What's the problem with
18 the form?

19 MR. GILL: I don't think that there's
20 any relevance or admissibility, but go ahead.

21 MR. PFLEIDERER: You can answer the
22 question.

23 MR. GUSE: I'm sorry. Can you read back
24 the question. I didn't catch it.

25 (Question read.)

1 **A** **When I reviewed the document, I was happy with it.**
2 **I didn't dissect it to a degree in which I could**
3 **verify every aspect being completely accurate, but**
4 **the overall context, I agreed with.**

5 BY MR. PFLEIDERER:

6 **Q** Was there anything in this document that you saw
7 that you believed to be inaccurate?

8 **A** **I would have to rereview it, to be honest, but do**
9 **you mean at that time?**

10 **Q** Yeah, at that time.

11 **A** **I signed off on it, so I'm assuming no.**

12 **Q** Okay. This is the last -- well, probably the last
13 thing that we're going to talk about. Okay.

14 (Discussion off the record.)

15 **Q** You're familiar with Scott Schara being the father
16 of Grace Schara?

17 **A** **Yes.**

18 **Q** Are you aware that -- or do you have any knowledge
19 of Scott Schara making public statements about
20 your care of Grace while she was in the hospital?

21 **A** **Yes.**

22 **Q** Okay. And has anybody contacted you as a result
23 of those statements, or has anybody threatened
24 you, do you believe, as a result of the statements
25 that Scott Schara has made?

1 **A** **The fallout from that was in large part negative**
2 **retaliation online in the -- in the aspect of**
3 **commentary. I did not get any -- I did not**
4 **receive any personal -- personal phone calls or**
5 **anything like that.**

6 **Q** **Did you receive any personal threats?**

7 **A** **I didn't receive any personal threats.**

8 **Q** **Did you receive any in-personal threats?**

9 **A** **Clarify that.**

10 **Q** **I don't know. Just thought I'd ask.**

11 And when you say commentary online,
12 are you talking about -- where are you seeing this
13 commentary?

14 **A** **First commentary I saw was actually on -- just**
15 **when you type in my name, there would be negative**
16 **commentary on Dr. Gavin Shokar on Google, for**
17 **instance.**

18 **Q** **When you type your name on Google, on a Google**
19 **search?**

20 **A** **Um-hmm, um-hmm, yep. Obviously, every article**
21 **that he has my name in is linked now to my name,**
22 **so everyone who Googles me has that.**

23 As well as, you know, the
24 commentary that has come down on Google, I have to
25 keep flagging to say it's inappropriate because

1 these are people that I don't even know and they
2 don't know the context of things, and they're
3 running on, you know -- I'm bound by HIPAA. I
4 can't say anything. I'm not -- I do not talk
5 about the case.

6 But the other side is able to talk
7 about whatever they want to talk about. So it
8 leads to, you know, an inappropriate perception
9 of -- a non-balanced perception of events. And so
10 the consequence is that I get negative reviews and
11 negative commentary online, and questions and
12 those kind of things. But...

13 Q And have those negative reviews, have they
14 affected your career, professional job?

15 MR. GUSE: Object to the form,
16 foundation, speculation. To your knowledge.

17 A The biggest effect they've had is on my
18 psychological well-being, I would say. There was
19 elements of security threats at the time when this
20 was going on. There was additional security that
21 had to be posted outside, you know, our car so we
22 had to be exiting particular entrances and exits.
23 It made me feel uncomfortable in Appleton in
24 general, because I didn't know who was reading
25 what.

1 And, yeah, so there was an overall
2 sense of, you know, a safety issue on one end, a
3 psychological issue on the other end. But as far
4 as a monetary thing, I'm a shift worker. I get
5 paid by shift. I have a job, so it hasn't been
6 able -- I haven't had a problem thus far, but I
7 transferred from an Ascension to Ascension
8 facility. I have no idea if I put my hat in
9 another system if they're going to Google review
10 me and it's going to be deleterious to my career.

11 BY MR. PFLEIDERER:

12 Q What did you mean by elements of security threats?

13 A Ascension actually had a security person watching
14 the exits when we entered and left because of all
15 the negative commotion that was going on online.

16 The -- the overall sense from the
17 hospital and all the physicians, nurses that --
18 you know, we were at -- a little bit at risk
19 because of this. Because, you know, when you have
20 this level of -- or this degree of response,
21 you're going to have the concern that there's
22 going to be -- it was going to be taken up a
23 notch.

24 And the medium that was used by
25 Scott and his family was -- the postings was on,

1 you know, places like Rumble.com and whatnot,
2 which is, you know, the perception was that the
3 audience of these media outlets would be more
4 readily to take action into their own hands and,
5 therefore, there was a perceived security issue
6 because of that, because of the chosen outlets and
7 the people associated and the commentary from
8 those pieces of media that were produced, which
9 included things like these people should all, you
10 know, you know -- basically negative, untoward
11 things of, you know, they -- I don't even -- I
12 didn't really try to look at any of the stuff, to
13 be honest. Initially it was just like rumors and
14 reports and I saw one video, but that was it. So
15 I can't really comment further on that.

16 Q As you sit here today, do you feel that there is a
17 physical threat to your safety because of Scott's
18 commentary?

19 A I still do.

20 Q You still do?

21 A I still do. It was another factor for me leaving
22 here. Not the main one, but it was definitely a
23 minor factor.

24 Q Has anybody ever personally in front of you ever
25 expressed anger towards you?

1 **A No. Actually, I'm thankful for that, yeah.**

2 MR. PFLEIDERER: I think we're done.

3 MR. GUSE: A little louder, please?

4 MR. PFLEIDERER: We're done.

5 MR. GUSE: Okay. Thank you.

6 Aaron and Jeremy, maybe we can
7 start with you guys on Zoom, if that's okay.

8 MR. BIRNBAUM: I don't have anything.

9 MR. GILL: Nothing here.

10 MR. POJE: I don't have anything.

11 MR. FRANCKOWIAK: Dr. Shokar, I just
12 have a couple of clarification questions for you.

13 **THE WITNESS: Sure.**

14 VIDEOGRAPHER: Microphone.

15 MR. FRANCKOWIAK: My name -- oh. Put
16 this on here.

17 VIDEOGRAPHER: Thanks.

18 MR. POJE: You're out of practice.

19 E X A M I N A T I O N

20 BY MR. FRANCKOWIAK:

21 Q I represent the hospital and the nurses, so I just
22 wanted to clarify a couple of things.

23 Going way back towards the
24 beginning of your deposition, there were some
25 questions that were put to you as to whether or

1 not you had personally observed any staff at the
2 hospital attempting to try to redirect Grace
3 without medication, for example, to handle her --
4 her agitation without medication.

5 Do you recall being asked those
6 questions?

7 **A Yes, I do.**

8 Q Okay. And you had mentioned that while you were
9 in the room, you didn't necessarily see any such
10 instances. Fair statement?

11 **A Correct. Yeah.**

12 Q When you would see -- when you would be in the
13 hospital seeing Grace, she would be one patient
14 that you would see, but you would have other
15 duties with other patients in the hospital, too?

16 **A Yes.**

17 Q Okay. So when you would be in her grace -- or in
18 Grace's room, would it be for limited periods of
19 time at any given point?

20 **A Yes.**

21 Q Okay. And would you anticipate that the nursing
22 staff would, of course, be -- have much more time
23 to spend with Grace than you necessarily would?

24 **A Yes, as a general structure, yeah.**

25 Q Okay. So in terms of whether or not the nursing

1 staff was expending efforts to try any number
2 of -- of behavioral modifications or redirection
3 during times when you were not in the room, you
4 wouldn't be able to speak to that, obviously?

5 **A There's no way, yeah.**

6 Q Okay. Now, I understand you also talked about --

7 **A Also, there wasn't -- I mean, many of the first**
8 **times there wasn't a nurse in the room when I saw**
9 **her the first day, for instance. They're around,**
10 **but they don't come in with me all the time.**
11 **Right?**

12 Q Oh. The nurses are in the room when you're not
13 there all the time?

14 **A Correct.**

15 Q There also have been -- you were asked a number of
16 questions on Precedex, for example, and you've
17 mentioned what the halflife of Precedex is and you
18 were aware she was on Precedex, and eventually you
19 did order the stoppage of the Precedex on the
20 13th.

21 You remember testifying about that?

22 **A Yes.**

23 Q Okay. Would it be fair to state that at least up
24 until the time that you ordered the stoppage of
25 the Precedex, the value of the Precedex or the

1 benefit of the Precedex outweighed any potential
2 drawbacks of the Precedex through that time?

3 MR. PFLEIDERER: Objection. You can
4 answer. I just -- I'm just objecting. You can
5 answer.

6 **A Sure. I -- yes, I would assume that the advantage**
7 **was outweighed -- outweighed, you know, the**
8 **negatives. A large part of that -- a large part**
9 **of the assessment of the value of Precedex and the**
10 **response to that would be done via the nursing,**
11 **you know, bedside, as well as in collaboration**
12 **with ICU attending, yeah. Um-hmm.**

13 BY MR. FRANCKOWIAK:

14 Q And if the nurses saw the increases in agitation,
15 they would handle the Precedex titration?

16 **A Correct, yes.**

17 Q Okay. Now, I think you had also mentioned -- you
18 also were asked some questions about that time on
19 the evening or the late afternoon of the 13th when
20 you were in the room managing the care of Grace,
21 and I think you said you -- Hollee McInnis was
22 there with you at the time.

23 Do you recall that?

24 **A Yes, yes.**

25 Q Okay. And it was during that time when, I

1 believe, you'd said you gave the verbal order for
2 morphine which was then administered?

3 **A Yes.**

4 Q Okay. And I believe you'd also mentioned that
5 after you were there in the room for a period of
6 time after that to kind of monitor Grace to see
7 how she was doing?

8 **A From the morphine?**

9 Q Yes.

10 **A Yes. After I gave the morphine, I was in the room**
11 **reassessing her, personally doing blood pressures**
12 **on her. Hollee was as well, you know, making sure**
13 **that things improved. That duration of time was a**
14 **good ten minutes, I would say. I felt comfortable**
15 **leaving that room that I could continue monitoring**
16 **from outside the room. Hollee was still in the**
17 **room, I believe.**

18 Q Okay. And I think you had mentioned that when you
19 left the room, based upon what you were seeing,
20 her reaction to that medication, is that she had
21 stabilized and you had believed she was stabilized
22 because of that intervention, the morphine that
23 you had ordered?

24 **A Yes, definitely. I felt, like, relieved that, oh,**
25 **my gosh, she stabilized, and her oxygenation --**

1 you know, remember, there's three monitors
2 attached to her, which was, you know, confusing.

3 Q Um-hmm.

4 A You know. And all three of them actually
5 improved, so I was, like, okay, we have consistent
6 reading, you know, her respiratory went back down
7 to 40, which is what she was doing previously as
8 well. It's not ideal, but it's still better than
9 60. And I felt the intervention was successful.

10 Q Okay. And then by the time you left the room and
11 you had noticed that she was stabilized based upon
12 what you were seeing after the administration of
13 the morphine, was there any reason in your mind at
14 that time to consider the use of a reversal drug
15 for the morphine, that the morphine might need to
16 be reversed in some manner for her safety?

17 A No, not at that time. Again, it was -- it was a
18 small dose, 2 milligrams. It was one time. She
19 hadn't been on opiates prior, you know. So if
20 you're on larger doses, usually with like morphine
21 equivalents of 50 and above is kind of -- you
22 know, if you -- that's kind of when you start
23 wondering about should we have naloxone handy, you
24 know. Even below that, if you want, depending on
25 the circumstances. But 2 milligrams, I didn't

1 **have any -- any inkling to say that we needed to**
2 **reverse 2 milligrams. That would have been --**

3 Q And this was not a situation that required you to
4 even consider a reversal drug, because it actually
5 had the effect you wanted it to have?

6 A **It worked, yeah. It worked. And if I reversed**
7 **it, then the concern she would be back to square**
8 **one with a respiratory rate that's too high and I**
9 **don't have anything else to give. And we can't**
10 **intubate, so...**

11 Q Okay. I think you had also mentioned at the time
12 during this same time about the Precedex being
13 turned off, and you mentioned that Hollee was in
14 the room. And Hollee was actually the one who
15 turned the Precedex off?

16 A **Yes, she was.**

17 Q And did you see her turn the Precedex off?

18 A **I saw her go to the IV, the area and was -- I**
19 **mean, I didn't directly see her turn which pump**
20 **off or whatnot, because I was managing Grace. But**
21 **she did walk over and start fiddling with the IV.**

22 Q And in terms then of when she actually put into
23 the record like the timing of the record for when
24 she turned it off, I assume you wouldn't be able
25 to speak to that?

1 **A** I have no -- I have no idea when she did that.
2 She was with me bedside, you know, I was telling
3 her let's do this, do this. So in between she was
4 trying to get back to the computer and floor, and
5 I'm not -- you know, trying to order the morphine,
6 trying to order this, you know, so I'm not -- I
7 have no idea when she actually put the order in.

8 **Q** And I think as we looked -- I think you were shown
9 like the medication order for the morphine. It
10 looks like it was maybe given at -- was it 1815
11 but it was entered 15 minutes later. That's not
12 unusual in a case of like an emergency situation?

13 **A** **It's not unusual, no.**

14 **Q** Okay. When Hollee gave her deposition, she
15 mentioned that that period of time when the
16 morphine was being given, the Precedex was being
17 turned off, the condition -- this was kind of an
18 emergency situation; would you agree?

19 **A** **Definitely.**

20 **Q** Okay. So in terms of in an emergency situation,
21 that's where you would be giving the orders and
22 you'd be administering medications and you'd worry
23 about putting notes in the record after you've
24 handled the emergency?

25 **A** **Yes, correct.**

1 Q Okay. I think you had also mentioned that you
2 were aware that Grace had recently received some
3 Ativan.

4 Do you remember around that time
5 when you were in her room knowing that she had
6 also received some recent Ativan?

7 A Yes.

8 Q Okay. And had Hollee informed you that she had
9 given some Ativan?

10 A Hollee called me prior to me getting to the
11 room --

12 Q Okay.

13 A -- and, you know, to kind of give me a report of,
14 hey, you know, she's hypoxic and we tried proning
15 and it's not working. And usually -- I had a
16 conversation say, well, what's -- give me the
17 status update, what's going on. Still very
18 tachypneic, respirations are high, hypoxic, in the
19 50s. She didn't tell me that there was two other
20 monitors on. I found out that later and whatnot,
21 but -- you know, so she was saying -- you know, I
22 tried to piece together what's the reason for it.
23 In my mind, I'm kind of, like, is this just an
24 escalation -- is this an escalation of the
25 inflammatory response, is this, you know, the next

1 part of that, or is this -- could this be from
2 anything else. And from her report, maybe she was
3 anxious still, you know, agitated, she's --
4 respiratory is at -- pretty high.

5 So my order to her was let's get
6 another -- let's give another dose of Ativan and
7 I'll be down in a sec to kind of, you know, see
8 what's going on.

9 Q Okay. So as I understand it, Hollee had given you
10 a call and established contact with you, let you
11 know how she was doing, and say, you know, Doctor,
12 I just gave her a dose of Ativan and it's not --
13 it's not accomplishing what we needed.

14 A Yeah. She got the regular scheduled dose of
15 Ativan at that time, I believe, but it wasn't
16 doing anything, and it was kind of a starting dose
17 as well, so we had room to go up on that if
18 needed.

19 You know, she -- my -- my -- my
20 idea was, okay, well, we already have Ativan
21 going, let's give her another .5, make it a
22 milligram. Because I think she just got Ativan
23 like, I don't know, 15 minutes ago or something.
24 Again, it wasn't doing anything for her.

25 So the only -- again, I had two

1 tools in the tool bag here, give a little bit
2 extra Ativan or give -- or switch to morphine, and
3 I wasn't going to do that without seeing her and
4 seeing the situation. So the first step was give
5 her an extra dose of Ativan, which is -- 1
6 milligram is not an unreasonable dose either. And
7 then I went down to assess her.

8 Q Okay, okay. And that was -- I think you'd also
9 mentioned because you were asked some questions
10 about what a PRN, what it means to be like a PRN
11 or Q4 or Q6, something like that.

12 A Um-hmm.

13 Q So if the Ativan in the record was a Q6, but the
14 records do indicate that Grace was given a Q6 dose
15 and then several minutes later Hollee administered
16 a second dose --

17 A Um-hmm.

18 Q -- that would be consistent with her obtaining
19 your order for that?

20 A Yeah.

21 Q And that's acceptable?

22 A Yeah. So she gave -- the initial dose was p.r.n.
23 or as-needed dose, which was already in the
24 medication, you know, list that she could give.
25 But for her to give anything else, she'd have to

1 ask me. You know, she needs authorization. So I
2 verbally ordered, you know, additional Ativan for
3 her to see, you know, what the effect would be in
4 hopes that it would reduce the respiratory rate or
5 help her out a little bit in oxygenation purposes.

6 Again, the going theory was either
7 she's declining and the next step is intubation,
8 which we weren't going to do, or could there be
9 something else going on like anxiety, you know,
10 in which case -- and we already knew she was
11 agitated. You know, she was on Precedex for that
12 reason. So the logical conclusion would have been
13 let's see if we can control the anxiety and
14 agitation more. Maybe that will help with the
15 oxygenation by reducing the respiratory rate.

16 ABGs had been pending all the time.
17 It was like, you know -- also ordering ABGs at the
18 time to -- to, you know, confirm from a -- from a
19 quantitative reason or the blood gas to see if
20 there's actually -- that PCO2 from before we were
21 talking about, and that PO2 to see what's going
22 on, yeah.

23 Q Okay. And in working with Hollee on the 12th and
24 the 13th, to your recollection did she implement
25 the orders that you gave her? Do you have any

1 reason to believe she didn't implement any of the
2 records you gave her or anything like that?

3 **A I mean, I would assume she implemented the orders.**
4 **She's a good nurse. She basically -- I mean, the**
5 **record probably reflects that she gave the extra**
6 **dose, I'm assuming.**

7 Q Okay.

8 **A Yeah.**

9 Q Okay. The last thing I have for you, I guess,
10 Doctor, is that in looking -- you did obviously
11 the discharge summary at the end that talks about
12 the care.

13 **A Um-hmm.**

14 Q When you drafted that, did you have any reason to
15 believe that Grace's death was related in any way
16 to the administration of any of the medications
17 that had been given to her on the evening of the
18 13th?

19 **A No. No, no, no.**

20 Q And as you sit here today, do you have any reason
21 to believe that her death ultimately was the
22 result of any of the medications or a combination
23 thereof that were given to her on the 13th?

24 **A No.**

25 MR. FRANCKOWIAK: Thank you, Doctor.

1 That's all I have.

2 MR. GUSE: Doctor, I just have a couple
3 clarifications questions.

4 **THE WITNESS: Sure.**

5 E X A M I N A T I O N

6 BY MR. GUSE:

7 Q One, you remember you were asked some questions at
8 the very beginning about -- in your initial note
9 about your commentary that Grace was somewhat
10 cooperative.

11 You recall those questions?

12 **A Yeah.**

13 Q When you indicate in the note that Grace was
14 somewhat cooperative, is that a criticism of
15 Grace, or is that just simply a clinical
16 observation?

17 **A It's not -- that's not a criticism. That's just
18 an observation to -- to -- it was more the
19 opposite. It was trying to elicit the fact that
20 she was trying.**

21 Q So from your perspective, it was more of a -- it
22 was meant to be more of a positive comment?

23 **A Yes.**

24 Q Again, based on your review of the records or the
25 chart in preparing the death summary, did you see

1 any evidence that Grace's death was caused by a
2 bacterial infection?

3 **A No.**

4 Q Any indication or any evidence in the record that
5 Grace's death was caused by legionnaires disease?

6 **A No.**

7 Q You were asked some questions towards the end of
8 counsel's questioning about -- concerns about your
9 safety and some of the commentary.

10 Are you aware of whether or not you
11 have been referred to as a killer or a murderer in
12 publications?

13 **A Yes.**

14 Q Does that cause you to be concerned about your
15 safety?

16 **A Yes, I mean, for retribution sake.**

17 Q You understand that this deposition today is being
18 recorded by video?

19 **A Yes.**

20 Q Do you have any concerns about -- strike that.

21 Should this video be published on
22 social media or in any other media, do you have --
23 would that cause you to be concerned about your
24 safety?

25 **A Yes.**

1 MR. PFLEIDERER: Object. You can
2 answer.

3 BY MR. GUSE:

4 Q Similarly, if the actual written transcript was
5 published on social media, on Facebook, or some
6 other medium, would that cause you concern for
7 your personal safety?

8 A Yes.

9 Q Do you have concerns about the impact of this case
10 in terms of the personal safety of your family?

11 A Yes.

12 Q Doctor, in terms of the care that you -- care and
13 treatment that you provided to Grace Schara on
14 October 12th and 13th, 2021, do you believe that
15 the care and treatment you provided met the
16 standard of care?

17 A Yes.

18 MR. GUSE: Thank you, Doctor.

19 MR. PFLEIDERER: Just a couple.

20 E X A M I N A T I O N

21 BY MR. PFLEIDERER:

22 Q Dr. Shokar, you just testified that certain
23 commentary in this case would lead you to have
24 concerns for the safety of your family.

25 A Yes.

1 Q Has anyone in your family received threats in
2 regard to the commentary in this case?

3 A No.

4 Q Has anybody, to your knowledge, ever physically
5 approached a member of your family?

6 A No.

7 MR. PFLEIDERER: Okay. That's all I
8 have. Thanks.

9 VIDEOGRAPHER: Thank you. This
10 concludes today's deposition of Gavin Shokar, M.D.
11 We are going off the record at 6:21 p.m.

12 (Deposition concluded at 6:21 p.m.)

13 (Original exhibits attached to Original
14 transcript; copies of exhibits are attached.)

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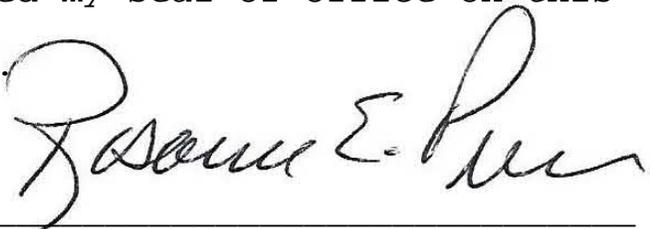
1 STATE OF WISCONSIN)
) SS:
 2 MILWAUKEE COUNTY)

3
 4 I, Rosanne E. Pezze, RPR/CSR/CRR
 5 and Notary Public in and for the State of
 6 Wisconsin, do hereby certify that the deposition
 7 of GAVIN SHOKAR, M.D. was recorded by me and
 8 reduced to writing under my personal direction.

9 I further certify that said
 10 deposition was taken at 1506 South Oneida Street,
 11 Appleton, Wisconsin, on the 22nd day of May, 2024,
 12 commencing at 1:07 p.m.

13 I further certify that I am not a
 14 relative or employee or attorney or counsel of any
 15 of the parties, or a relative or employee of such
 16 attorney or counsel, or financially interested
 17 directly or indirectly in this action.

18 In witness whereof, I have hereunto
 19 set my hand and affixed my seal of office on this
 20 2nd day of June, 2024.



21
 22 _____
 ROSANNE E. PEZZE, RPR/CSR/CRR
 Notary Public

23 My commission expires January 10, 2026

24
 25

Exhibits			
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